

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH 71-04587

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vera T. Abbaticchio</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-17-79</b> |  |  | 2b. HOUR <b>1:15 P.M.</b>  |  |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 15 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>POTOMAC VALLEY NURSING HOME</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET. ADM. OFFICER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>NAVY DEPT.</b>  |  |  |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>MONTGOMERY</b>   |   | 13c. CITY OR TOWN <b>GAITHERSBURG</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>436 GIRARD ST.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>CLARENCE TYLER</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA FROST</b>  |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>087-20-2436</b>   |   | 17. INFORMANT ADDRESS <b>Gaithersburg, TONI A. ABBATICCHIO 102 Duvall La., Md.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adeno Ca of lung</b><br><b>1639</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 mos</b> |  |   |   |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD; Ray fracture</b>   |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>1-18-79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ray fracture</b>  |   |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 18 1977</b> to <b>Feb 17 1979</b> , that (I) (we) lost saw the deceased alive on <b>FEB 19 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  | 22c. DATE SIGNED <b>2-17-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. S. S. AIA</b>   |  | 22e. ADDRESS <b>809 Uivers N. 111 Md</b>  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>2-19-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Fairfax Va.</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES P/A</b>   |  | ADDRESS <b>ROCKVILLE MD.</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

100-4201



100-4201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |                  |  |  |  |  |  |                               |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                     |  |  |  |  |  |  |  | REG. NO. 79-04588                                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|------------------|--|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Rose Mervin Adaboje   |  |                  |  |  |  |  |  |                               |  | 2b. DATE KNOWN OF DEATH ESTI-MATED<br>Feb 9 1979   |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD<br>Feb-9 1979   |  |                     |  |  |  |  |  |  |  | 2d. HOUR<br>1:14 PM                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>B I K |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar 21 39 |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>39 |  | 7. IF UNDER 1 YR. MONTHS DAYS |  | 7. IF UNDER 24 HRS. HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>Feb-9 1979 |  |  |  |  |  |  |  |  |  | 2d. HOUR<br>1:14 PM |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  |                  |  |  |  |  |  |                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                     |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD. |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Tak Park   |  |                  |  |  |  |  |  |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wash Advent Hosp        |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                     |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Md   |  |                  |  |  |  |  |  |                               |  | 13b. COUNTY<br>Baltimore   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                     |  |  |  |  |  |  |  | 13e. STREET ADDRESS<br>907 N Carrollton Ave            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EVERETT BONNER   |  |                  |  |  |  |  |  |                               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>PEARL  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |                     |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-36-0422                |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS<br>CAROLE BRIGHT SAME |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4410 Esophageal Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Disssecting Ascending Aortic Aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                  |  |  |  |  |  |                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None              |  |                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>2-9-79  |  |                  |  |  |  |  |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>Repair of Disssecting, ascending aortic aneurysm                              |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  |  |  |  |  |                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |  |  |  |  |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                  |  |  |  |  |  |                               |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)<br>M.D. 1208 MEDICAL EXAMINER  |  |                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Joseph P. Jones   |  |                  |  |  |  |  |  |                               |  | DATE SIGNED<br>Feb 10, 1979  |  |  |  |  |  |  |  |  |  | EXAMINER'S NAME (TYPE OR PRINT)<br>ADDRESS   |  |                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  |  |  |  |  |                               |  | 23b. DATE<br>2-14-79   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. CALVARY Cem.   |  |                     |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>VERNON Bailey  |  |                  |  |  |  |  |  |                               |  | ADDRESS<br>1348 CALHOUN ST.  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1979   |  |                     |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Kelly              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

19-04208





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | REG. NO. <b>79-04589</b>                        |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles F. Agee</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>13</b> YEAR <b>79</b>  |  | 2b. HOUR<br><b>3:10 P M</b>                     |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>July</b> DAY <b>6</b> YEAR <b>1904</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                     |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mill Wright</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Virginia</b>   |  | 13b COUNTY<br><b>Atkins</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>Route 1, Box 168</b>  |  |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Agee</b> LAST <b></b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Belle</b> MIDDLE <b>Kegley</b> LAST <b></b>   |  |   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 17 INFORMANT ADDRESS<br><b>Mrs. Flossie M. Agee (Wife) Rt 1, Box 168 Atkins, Va.</b>   |  |   |  |   |  |   |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pneumonia</b>  |  |   |  |  |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 3</b> 19 <b>79</b> , to <b>Feb 13</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 13</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Bernard A. Fitzgerald MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>2-13-79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>   |  |   |  | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD E. SILVER SPRING, MD 20801</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>02-17-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Meml. Gardens</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Rural Retreat</b> COUNTY <b>Virginia</b> STATE <b></b> |  |   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Hines/Rinaldi Funeral Home, Inc.</b><br>ADDRESS <b>11800 New Hampshire Ave, Silver Spring, Md.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1979</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>   |  |   |  |

98240-01



19-01-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

79-04591

|   |  |                  |   |                                   |  |   |   |  |   |  |                                |   |  |  |
|---|--|------------------|---|-----------------------------------|--|---|---|--|---|--|--------------------------------|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Anna VMN AMBOS   |  |                  | 2a. DATE OF DEATH<br>Month Day Year<br>2-21-1979  |                                   |  | 2b. HOUR<br>6:02 AM   |   |  |   |  |                                |   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE |   | 5. DATE OF BIRTH<br>APRIL 2, 1892 |  |   | 6. AGE (In years<br>last birthday)<br>86 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN. |   |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>AUSTRIA   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br>MONTGOMERY  |  |                                | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>WASHINGTON ADVENTIST HOSP. |                                   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |                                |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>NEW YORK  |  |                  | 13b. COUNTY<br>BRONX  |                                   |  | 13c. CITY OR TOWN<br>BRONX  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                | 13e. STREET AND NUMBER<br>399 EAST 160th STREET |  |  |
| 14. FATHER'S NAME First Middle Last<br>JOHN POJE  |  |                  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>KATHERINE OSTERMAN  |                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, NO (If unknown) (If yes give war or dates of service)  |   |  | 16b. SOCIAL SECURITY NO.<br>119-36-0078   |  |                                | 17. INFORMANT<br>DAUGHTER<br>MADLEINE L. PARKER |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 486- pneumonia - LLL<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>7 WKS.   |                                   |  |   |   |  |   |  |                                |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>CHF   |  |                  |   |                                   |  |   |   |  |   |  |                                |   |  |  |
| 19a. DATE OF OPERATION  |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                                |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |                                |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |                                |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/5, 1979 to 2/21, 1979, that (1) (we) last<br>saw the deceased alive on 2/20/1979 and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (1) (we) (did) (did not) view the body after death. |  |                  |   |                                   |  |   |   |  |   |  |                                |   |  |  |
| 22b. SIGNATURE<br>David Cromwell  |  |                  | 22c. DATE SIGNED<br>2/21/79   |                                   |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>DAVID CROMWELL   |   |  | 22e. ADDRESS<br>831 UNIV. BLVD., E., SILVER SPRING, MD.   |  |                                |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  |                  | 23b. DATE<br>2/24/79  |                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN CEMETERY   |   |  | 23d. LOCATION (City or Town) (County) (State)<br>BRONX NEW YORK                                 |  |                                |   |  |  |
| 24. FUNERAL DIRECTOR<br>FRANCIS J. COLLINS  |  |                  | ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |                                   |  | 25a. RECEIVED BY REGISTRAR<br>FEB 22 1979   |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |   |  |  |

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WHITE

MONTGOMERY

U.S.A.

WATKINS

HOUSE THE

WASHINGTON AMBASSY POST

TAKOMA PARK

399 EAST 1800 STREET

BROWN X

WATKINS

TUTMAN

WATKINS

TOE

JOHN

812 11TH AVENUE  
WATKINS

110-26-0078 WATKINS J. PARKER  
DANIEL

831 WATKINS BLVD. I. ST. SPRING

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                              |  |   |  |   |  |   |   | 79-04592  |   |  |
|---|--|------------------------------|--|---|--|---|--|---|---|---|---|--|
| 1- STATE REGISTRAR  |  |                              |  |   |  |   |  |   |   | REG. NO.  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edmund L. Andrews, Jr.</b>  |  |                              |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>2/27/1979</b>   |  | 2b. HOUR<br><b>11:45 P.M.</b>                     |   |   |   |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>      |  | 5. DATE OF BIRTH<br>MONTH YEAR <b>Oct. 5, 1928</b>          |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>50 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS                        |   | IF UNDER 24 HRS. HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  |                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreign Serv. Off.</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov't.</b>                                  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              |  |   |  |   |  |   |   |   |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montg.</b> |  | 13c. CITY OR TOWN<br><b>Bethesda</b>                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>8001 Beech Tree Rd.</b> |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edmund L. Andrews, Sr.</b>   |  |                              |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Pratt</b>   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  |                              |  | 16b. SOCIAL SECURITY NO.<br><b>Korean</b>                   |  | 17. INFORMANT<br><b>Margaret Andrews</b>  |  |   |   | ADDRESS<br><b>same as 13</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Hypertensive Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                              |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                              |  |   |  |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                              |  |   |  |   |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |  |                              |  | TITLE (SPECIFY)<br><b>Deputy</b>                            |  |   |  | DATE SIGNED<br><b>Feb 27, 1979</b>                |   |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball</b>   |  |                              |  | ADDRESS<br><b>7936 Old Georgetown Rd. Bethesda, Md.</b>     |  |   |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                              |  | 23b. DATE<br><b>Mar. 2, 1979</b>                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>   |  |                              |  |   |  | ADDRESS<br><b>Homes, P.A. Bethesda, Md.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1979</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b> |  |

79-04282

Edmund J. Andrews, Jr. 2-27-79

2/27/79

Illinois USA

Beckstein Suburban Hospital 1001 Beck Street

Beckstein, Illinois 6001 Beck Street

Edmund J. Andrews, Jr. 1111111111

For 1000-10-2181 1111111111 same as 12

John C. Hall 1934 Old Georgetown Road

Robert A. Humphrey Funeral Home, J.A. Beckstein, Ill. 1111111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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86  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 79-04593   |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.   |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST<br>Malcolm   |  |  | MIDDLE<br>J.  |  |  | LAST<br>Annadale   |  |  |
| 2a. DATE OF DEATH  |  |  | MONTH<br>Feb.  |  |  | DAY<br>28,  |  |  | YEAR<br>1979   |  |  |
| 2b. HOUR   |  |  | 5:45 P   |  |  | M   |  |  |  |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 22, 1899   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Kensington  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kensington Gardens |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ret.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Montgomery  |  |  | 13c. CITY OR TOWN<br>Silver Spring  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel T. Annadale   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna A. Hall  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>216-22-2390A   |  |  |
| 17. INFORMANT<br>2120 Sudbury Rd.<br>Dorothy A. Warfield Silver Spring, Md.  |  |  |  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic heart disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>years</u> |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 12</u> , 19 <u>79</u> , to <u>Feb 28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Feb 20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Smith M.D.</u>  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br><u>2/28/79</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>A.W. SMITH</u>   |  |  | 22e. ADDRESS<br><u>13018 Georgia Ave<br/>Wheaton, Md.</u>  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Mar. 3, 79  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glenwood Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi Funeral Home  |  |  | 11800 New Hampshire<br>Silver Spring, Md.  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>P. J. Brady</u>   |  |  |

10-04203



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-04594   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE REGISTRAR   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Pearl Aronow</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 9, 1979</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 20, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Potomac, Montgomery County MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Potomac</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10613 Gainsborough Road</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Potomac</b>   |  | 13e. STREET ADDRESS<br><b>10613 Gainsborough Road</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leonard ----- Lewiton</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah ----- Katz</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>075-16-8381</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Potomac, Md.<br/>Lewis Aronow, 10613 Gainsborough Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma pancreas - 6 mos</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 24, 1978</b> , to <b>Feb 9, 1979</b> , that (I) (we) last saw the deceased alive on <b>Feb 8, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Horace Bernton</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9 Feb 79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Horace Bernton, M. D.</b>   |  |   |  | 22e. ADDRESS<br><b>4743 Bradley Blvd., Chevy Chase, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2-10-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, P. Geo. Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Mem. Chap. Rockville, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 15 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McReady</b>   |  |

BP

10210-01



10210-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 73-04595

|   |  |   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard Bailes</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/1/79</b> |   |  | 2b. HOUR<br><b>1AM</b>  |  |  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 6 16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn. WA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda, MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack - Bailes</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Molly Weintraub</b>   |  |   |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>102-10-2533</b>  |  | 17. INFORMANT<br><b>Joel H. Bailes</b><br>ADDRESS<br><b>3672 Providence Road<br/>Newtown Square, Pa. 19073</b>  |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Lymphoma, Large Cell Type, Diffuse</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____  |  |   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>1/20/78</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Same as above</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/29</b> , 19 <b>79</b> , to <b>2/1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.             |  |   |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Wesley B. Mason</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |  | 22c. DATE SIGNED<br><b>2/1/79</b>   |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wesley B. Mason</b>   |  |   |  | 22e. ADDRESS<br><b>10500 Knowles Ave, Kensington, MD.</b>   |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/2/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Lebanon Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hyattsville, Maryland</b>                      |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Donald M. Stein Hebrew Memorial F.H.</b><br><b>232 Carroll Street, N. W. Washington, D. C.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1979</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McCreedy</b>   |  |   |  |  |   |

MEDICAL CERTIFICATION

202.80010-02

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 15, 15 g529 3/22/79 gj  
FOR  
1- STATE #15, Film G625 3/6/87 kam  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04596

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Mary AGNES Barrett  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>2-28-1979  |  | 2b HOUR<br>10:40 A.M.   |  |
| 3 SEX<br>FEMALE   | 4 RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 26 1887   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, DC  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |  |
| 10 CITY OR TOWN OF DEATH<br>TAKOMA PARK   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |   | 12b KIND OF BUSINESS OR INDUSTRY       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>WASHINGTON DC |  | 13b COUNTY   | 13c CITY OR TOWN<br>DC   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>3033 16th ST. NW |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN F O'CONNOR  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Margaret Kyne   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT<br>ADDRESS<br>ROBERT W. BARRETT - 3033 16th ST. NW                     |  |

|   |  |   |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Terminal gram negative septicemia<br>0384<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) —<br>(c) —<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2/17/79 |
|---|--|---|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 19c AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21a INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21b PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21c LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from 2/17/79, 19, to 2/28/79, 19, that (I) (we) last saw the deceased alive on 2/28/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b SIGNATURE<br>OSOTH LEKAGUL MD   |  | DEGREE<br>MD  |  | 22c DATE SIGNED<br>2/28/79  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS   |  |   |  |
| OSOTH LEKAGUL MD  |  | 7425 Arlington Rd Bethesda MD   |  |   |  |

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial          |  | 23b DATE<br>Mar. 2, 1979                              |  | 23c NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery Silver Spring Md. |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE      |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>J.A. Walters, TAKOMA F.H., Inc. |  | ADDRESS<br>284 CARROLL ST., N.W.<br>WASH., D.C. 20012 |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 5 1979                                     |  | 25b REGISTRAR'S SIGNATURE<br>Robert W. Barrett |  |

BP

Handwritten notes, mostly illegible due to fading. Some visible words include "yesterday", "today", "tomorrow", "yesterday", "today", "tomorrow", "yesterday", "today", "tomorrow".

Handwritten notes at the bottom of the page, mostly illegible due to fading. Some visible words include "yesterday", "today", "tomorrow", "yesterday", "today", "tomorrow", "yesterday", "today", "tomorrow".

Released by Dr. Mayle  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |                                  |  |   |  |
|---|--|--|--|---|--|--|----------------------------------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 79-04597   |  |   |  | REG. NO.   |                                  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM ASHBY BEAL   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 25 79                 |  |                                  | 2b. HOUR<br>4:06 P.M.  |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 8, 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash., D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clergy           |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Church  |   |  |
| 13a. STATE<br>Md.   |  |  |  |   | 13b. COUNTY<br>Montg.  |  | 13c. CITY OR TOWN<br>Chevy Chase |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter Beal   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eleanor Ashby |  |                                  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW II  |  | 17. INFORMANT<br>Patricia R. Beal   |  | ADDRESS<br>Same as 13  |                                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br>410- DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Immediate</u>     |  |  |  |   |  |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |  |                                  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>several years</u> 19 <u>79</u> , to <u>2-25</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>a few months</u> 19 <u>ago</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. |  |  |  |   |  |  |                                  |  |   |  |
| 22b. SIGNATURE<br><u>Des Leanne M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |                                  | 22c. DATE SIGNED<br>2-25-79  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSCAR MANN M.D.  |  |  |  | 22e. ADDRESS<br>3301 NEW MEXICO AV WASH DC 20016  |  |  |                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Cremation  |  | 23b. DATE<br>Feb. 26, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Va.                        |                                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Homes, P.A.   |  |  |  | ADDRESS<br>Bethesda, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 01 1979   |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>Pitney Keating</u>  |   |  |

751.8.59

2001-2002

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1998



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04598

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |  |   |  |  |
|---|--|---|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice Belisle</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-3-79</b>                             |  |  | 2b. HOUR<br><b>8:35 AM</b>   |  |   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 16 99</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rhode Island</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housekeeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Catholic Nun</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Prince George's</b>   |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anselme Belisle</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Louise Leveille</b> |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>092-42-0391</b> |  |
| 17. INFORMANT<br><b>Sister Irene Rheume</b>   |  |   | 18. ADDRESS<br><b>same as 13</b>  |  |  | 19. DATE OF OPERATION  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myelocytic Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diphtheria Mellitus</b>   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                 |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Diphtheria Mellitus</b> |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2nd</b> , 19 <b>76</b> , to <b>February 3</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>February 2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Hugo G. Graziani, M.D.</b>   |  |   | DEGREE<br><b>M.D.</b>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                       |  | 22c. DATE SIGNED<br><b>2-3-79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hugo G. Graziani</b>  |  |   | 22e. ADDRESS<br><b>800 PERSHING Dr 303A SS Md 20900</b>                       |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb. 5, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Regina Convent Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hyattsville Pr. Geo. Md.</b>        |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis J. Collins</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1979</b>                            |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |
| 500 University Blvd., W. Silver Spring, Md.   |  |   |   |  |  |  |  |   |  |  |

MEDICAL CERTIFICATION

1

80210-07

[illegible]

1055-1100

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

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2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

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1950-51-390

5.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04599

|  |                           |  |   |   |   |
|--|---------------------------|--|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dock Henzley Bethea   |                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-14-79  |   | 2b. HOUR<br>4:45 P.M.                           |
| 3 SEX<br>Male  | 4 RACE<br>Black           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 25, 1919   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  |                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10 CITY OR TOWN OF DEATH<br>Takoma Park  |                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hospital               |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer   |                           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                           |  |   |   |   |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Montgomery | 13c. CITY OR TOWN<br>Silver Spring   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>75 East Wayne Avenue   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Bethea   |                           |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Paige                                    |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |                           | 16b. SOCIAL SECURITY NO.<br>250-30-2534  |   | 17 INFORMANT<br>ADDRESS<br>Silver Spring, Md.<br>Dock H. Bethea Jr., 75 E Wayne Ave.  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Adenocarcinoma, Metastatic Lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) C.O.P.D., Anemia<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>A-S-N-D, Hypercholesterolemia C.V. disease |                           |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18/79, 19 79, to 2/14/79, 19 79, that (I) (we) last saw the deceased alive on 2/14/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                           |  |   |   |   |
| 22b. SIGNATURE<br>(Signature)  |                           | DEGREE<br>M.D.   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V C VAID  |                           | 22e. ADDRESS<br>7676 New Hampshire Ave Layley Park   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |                           | 23b. DATE<br>16 Feb 79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ship - to   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Mulling, South Carolina  |                           |  |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. ERNEST JARVIS CO. INC.  |                           | ADDRESS<br>1432 400 STREET NW  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1979  |   |
|  |                           |  |   | 25b. REGISTRAR'S SIGNATURE<br>(Signature)   |   |

BP

79-01299

UNIT 100  
DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

79-01299

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UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

UNIT 100

**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. **NOT TO FUNERAL DIRECTOR:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE FUNERAL DIRECTOR BY TELEPHONE. **NOT TO BURIAL OR CREMATION:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE BURIAL OR CREMATION SERVICE BY TELEPHONE.

1900 BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| STATE OF MARYLAND   |  |  |  |  |  |  |  |  |  |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
| REC. NO. 79-04600   |  |  |  |  |  |  |  |  |  |
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR 2b. HOUR P. M.  |  |  |  |  |  |  |  |  |  |
| Rudolph A. Bianconcini 2/15 1979 4:00 P. M.   |  |  |  |  |  |  |  |  |  |
| 3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. YRS. 8. IF UNDER 1 YR. MONTHS DAYS 9. IF UNDER 24 HRS. HOURS MIN. 10. DATE PRONOUNCED DEATH MONTH DAY YEAR 11. HOUR P. M.                       |  |  |  |  |  |  |  |  |  |
| Male White May 9, 1889 89 YRS. 2/16 1979 4:50 P. M.   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED WIDOWED DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH MD.   |  |  |  |  |  |  |  |  |  |
| Italy USA 8. MARRIED NEVER MARRIED WIDOWED DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH MD.  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |  |  |  |  |  |
| Silver Spring 7902 Long Branch Parkway Ret. Govt. Govt.   |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS  |  |  |  |  |  |  |  |  |  |
| Maryland Montgomery Silver Spring YES NO 7902 Long Branch Parkway   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  |
| Unknown Unknown   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS   |  |  |  |  |  |  |  |  |  |
| Yes WW 1 114-07-6284 R. Appet 46 Pier Lane, Fairfield, N.J.   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |
| 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |
| None  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?   |  |  |  |  |  |  |  |  |  |
| None 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                              |  |  |  |  |  |  |  |  |  |
| None 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                         |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner                          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner                          |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE TITLE (SPECIFY) DATE SIGNED  |  |  |  |  |  |  |  |  |  |
| John S. Rogers, M.D. Deputy Medical Examiner 2/16/79  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS   |  |  |  |  |  |  |  |  |  |
| John S. Rogers, M.D. 1919 Seminary Road Silver Spring, Montgomery, Md.  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| Cremation Feb. 18, 79 Metro. Crematory Alex. Va.  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |
| Warner E. Pumphrey 8434 Georgia Ave. Sil. Spr., Md. FEB 26 1979   |  |  |  |  |  |  |  |  |  |

79-04800

1914



TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 should be deposited for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04601

|   |   |   |  |  |
|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><u>BILLINGSLEY, Ernest Leavelle</u>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>2 8-79</u>  |  | 2b. HOUR<br><u>8-15 PM</u>                                       |
| 3. SEX<br><u>Male</u>   | 4. RACE<br><u>Cauc.</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>April 6, 1914</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>64</u><br>YRS. MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Virginia</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Bethesda</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Hill Center</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Ret. Captain</u>                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Army</u>            |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Md.</u> 13b. COUNTY <u>St. Mary's</u> 13c. CITY OR TOWN <u>Lex. Park</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>336 Midway Drive</u>  |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Addison Gordon Billingsley</u>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Ellie Leavelle</u>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>YES</u>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>1942-1962</u>   | 17. INFORMANT<br>ADDRESS<br><u>Nan Billingsley dame as 13e</u>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>410- DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>ASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden.</u> |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Wernicke-Korsakoff Encephalopathy.</u>   |   |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 74</u> to <u>8 Feb</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8 Feb</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |
| 22b. SIGNATURE<br><u>Michael Emmer</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Michael Emmer</u>   |   | 22e. ADDRESS<br><u>Bethesda, Maryland</u>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  | 23b. DATE<br><u>2-10-79</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oakhill Cemetery</u>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Fredericksburg Spottsylvania VA.</u>                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Bishop Funeral Home, P.A. Leonardtown, MD.</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>FFR 1-1076</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

BP



10010-07

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04602

|  |               |   |  |   |  |   |  |   |                                   |   |  |                    |  |
|--|---------------|---|--|---|--|---|--|---|-----------------------------------|---|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |               | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 2-10-79 <input type="checkbox"/> 2-10-79 |                                   |   |  | 2b. HOUR<br>1 P.M. |  |
| Mary ELIZABETH (BETTY) Bligh   |               |   |  |   |  |   |  |   |                                   |   |  |                    |  |
| 3. SEX<br>F  | 4. RACE<br>W. | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-4-1921  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>57 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>7-6-10-79   |                                   | 2d. HOUR<br>1 P.M.                            |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH. D.C.  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |                                   |   |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                      |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |                    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |               |   |  |   |  |   |  |   |                                   |   |  |                    |  |
| 13a. STATE<br>MD   |               | 13b. COUNTY<br>MONT.  |  | 13c. CITY OR TOWN<br>ROCKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>10224 ROCKVILLE PIKE   |                                   |   |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LUKE C. O'BRIEN  |               |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE KATHERINE SHEA   |  |   |  |   |                                   |   |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |               |   |  | 16b. SOCIAL SECURITY NO.<br>578 22 6086   |  | 17. INFORMANT<br>ADDRESS<br>HUSBAND - JAMES BLIGH - BETH. MD 22016                              |  |   |                                   |   |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Small Bowel obstruction &amp; Sepsis.</u><br>5680 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) <u>Multiple Fibrous Adhesions intraabdominal.</u><br>} DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Renal Failure - Sec. to Prolonged Shock - Acute &amp; Chronic Alcoholism -</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Days -<br>years |               |   |  |   |  |   |  |   |                                   |   |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Renal Failure - Sec. to Prolonged Shock - Acute &amp; Chronic Alcoholism -</u>   |               |   |  |   |  |   |  |   |                                   |   |  |                    |  |
| 19a. DATE OF OPERATION   |               |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                   |   |  |                    |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |               |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |                                   |   |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |               |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |   |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |               |   |  |   |  |   |  |   |                                   |   |  |                    |  |
| ACTUAL SIGNATURE<br>John B. Bell   |               |   |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |  | DATE SIGNED<br>Feb 11 1979  |                                   |   |  |                    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |               |   |  | ADDRESS   |  |   |  |   |                                   |   |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |               | 23b. DATE<br>2-13-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. GABRIEL'S Cem.  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>POTOMAC MONT. MD.   |                                   |   |  |                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James E. Bell  |               |   |  | ADDRESS<br>DEVOL FUNERAL HOME<br>WASHINGTON, D.C.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1979  |                                   | 25b. REGISTRAR'S SIGNATURE<br>Hickey McCreedy |  |                    |  |

82-01805

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |   |  | REG. NO. 79-04603   |  |                           |  |
|--|--|---|--|--|---|--|--|---|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Ida Bondareff</b>  |  |   |  |  |   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 1, 1979</b>  |  | 2b. HOUR <b>2:40 A.M.</b> |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>August 22, 1892</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>                            |  |   |  |   |  |                           |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) <b>Carroll Street Hebrew Memorial F.H. 232 Second Ave, Silver Spring MD</b> |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>  |  |                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |   |  |  |   |  |   |  |                           |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Silver Spring</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2309 Colston Drive</b>   |  |   |  |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Gurevich</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Losner</b> |  |  |   |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>587-46-3786</b>  |   | 17. INFORMANT ADDRESS <b>Mrs. Helen B Feldberg Same as No. 13</b>                            |  |   |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Pulmonary edema</b>  |  |   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>  |  |                           |  |
| 5184 } DUE TO, OR AS A CONSEQUENCE OF (b) _____  |  |   |  |  |   |  |  |   |  |   |  |                           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |  |   |  |  |   |  |   |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Dehites Mucitus</b>  |  |   |  |  |   |  |  |   |  |   |  |                           |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/12 19 79</b>  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |  |   |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |                           |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1/13/79</b> to <b>2/1/79</b> , that (we) lost saw the deceased alive on <b>1/13/79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death. |  |   |  |  |   |  |  |   |  |   |  |                           |  |
| 22b. SIGNATURE <b>J. Blaine Fitzgerald M.D.</b> (DEGREE)   |  |   |  |  |   |  |  | 22c. DATE SIGNED <b>2/1/79</b>  |  |   |  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Blaine Fitzgerald M.D.</b>   |  |   |  |  |   |  |  | 22e. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Maryland</b>                                   |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |   |  | 23b. DATE <b>2/2/1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>                              |  |   |  |                           |  |
| 24. FUNERAL DIRECTOR <b>Donald M. Stein Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C.</b>   |  |   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |   |  |                           |  |

72-04603

Cleared by Dr. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04604

|  |  |  |  |  |   |  |   |  |  |
|--|--|--|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Charles Daniel Boone</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-27-79</b>                   |  |   | 2b HOUR<br><b>10:20 P</b>  |   |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/28/1898</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS  |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>10:20 P</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                               |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Federal Employee</b> |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Post Office</b>   |  |
| 13a STATE<br><b>Maryland</b>   |  |  | 13b COUNTY<br><b>Montgomery</b>  |  | 13c CITY OR TOWN<br><b>Gaithersburg</b>                             |  | 13d INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>           |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard A. Boone</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Victoria Burch</b> |  |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>No</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>220-40-2691A</b>                         |  | 17 INFORMANT<br>ADDRESS<br><b>Margaret R. Boone, same as #13</b>    |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma lung terminal</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |   |  |   |  |  |
| 19a DATE OF OPERATION<br><b>None</b>   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |   |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>2-27-79</b> to <b>2-27-79</b> , that (I) (we) last saw the deceased alive on <b>2-27-79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |   |  |  |
| 22b SIGNATURE<br><b>V.S. de Guzman</b> DEGREE <b>MD</b>  |  |  |  |  |   | 22c DATE SIGNED<br><b>2-28-79</b>  |   | 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V.S. de Guzman</b>  |  |
| 22e ADDRESS<br><b>1234 19 NW WASH DC</b>   |  |  |  |  |   |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b DATE<br><b>3/2/79</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Maryland</b> |  |  |
| 24 FUNERAL DIRECTOR<br><b>Robert A. Pumphrey Funeral Homes, P.A.</b>   |  |  |  |  |   | 25a DATE REG'D. BY REGISTRAR<br><b>MAR 5 1979</b>  |   |  |  |
| 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |   |  |   |  |  |

100-01004

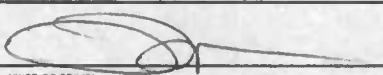



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-04605   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MILTON E. BRADY  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br>2 21 79 11:20 P.M.  |  |  |  |
| 3 SEX<br>male  |  | 4 RACE<br>white  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>6 12 00  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bethesda Health Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fed. Govt   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Prince Geo.   |  | 13c. CITY OR TOWN<br>Mt. Rainier   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>John W. Brady  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sarah Morris   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>none   |  | 17. INFORMANT ADDRESS<br>MARIE SUIT 3545 TERRACE DR. SUITLAND, MD.   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal cerebral thrombosis</u><br>4340<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/24/78, 19____, to 2/21/79, 19____, that (I) (we) last saw the deceased alive on 2/21/79, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>  |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED<br>2/21/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G.P. KALAS LEXAOL MD  |  |  |  | 22e. ADDRESS<br>7425 Arlington Rd Bethesda MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/26/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Epiphany Church Cem  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Frostville Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>G.P. Kalas 6160 Olden Hill Rd. Olden Hill, MD   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>        |  |

BP

1. Name of the plant: *Passiflora*  
2. Name of the fruit: *Passiflora*  
3. Name of the seed: *Passiflora*  
4. Name of the leaf: *Passiflora*  
5. Name of the flower: *Passiflora*  
6. Name of the fruit: *Passiflora*  
7. Name of the seed: *Passiflora*  
8. Name of the leaf: *Passiflora*  
9. Name of the flower: *Passiflora*  
10. Name of the fruit: *Passiflora*  
11. Name of the seed: *Passiflora*  
12. Name of the leaf: *Passiflora*  
13. Name of the flower: *Passiflora*  
14. Name of the fruit: *Passiflora*  
15. Name of the seed: *Passiflora*  
16. Name of the leaf: *Passiflora*  
17. Name of the flower: *Passiflora*  
18. Name of the fruit: *Passiflora*  
19. Name of the seed: *Passiflora*  
20. Name of the leaf: *Passiflora*  
21. Name of the flower: *Passiflora*  
22. Name of the fruit: *Passiflora*  
23. Name of the seed: *Passiflora*  
24. Name of the leaf: *Passiflora*  
25. Name of the flower: *Passiflora*  
26. Name of the fruit: *Passiflora*  
27. Name of the seed: *Passiflora*  
28. Name of the leaf: *Passiflora*  
29. Name of the flower: *Passiflora*  
30. Name of the fruit: *Passiflora*  
31. Name of the seed: *Passiflora*  
32. Name of the leaf: *Passiflora*  
33. Name of the flower: *Passiflora*  
34. Name of the fruit: *Passiflora*  
35. Name of the seed: *Passiflora*  
36. Name of the leaf: *Passiflora*  
37. Name of the flower: *Passiflora*  
38. Name of the fruit: *Passiflora*  
39. Name of the seed: *Passiflora*  
40. Name of the leaf: *Passiflora*  
41. Name of the flower: *Passiflora*  
42. Name of the fruit: *Passiflora*  
43. Name of the seed: *Passiflora*  
44. Name of the leaf: *Passiflora*  
45. Name of the flower: *Passiflora*  
46. Name of the fruit: *Passiflora*  
47. Name of the seed: *Passiflora*  
48. Name of the leaf: *Passiflora*  
49. Name of the flower: *Passiflora*  
50. Name of the fruit: *Passiflora*  
51. Name of the seed: *Passiflora*  
52. Name of the leaf: *Passiflora*  
53. Name of the flower: *Passiflora*  
54. Name of the fruit: *Passiflora*  
55. Name of the seed: *Passiflora*  
56. Name of the leaf: *Passiflora*  
57. Name of the flower: *Passiflora*  
58. Name of the fruit: *Passiflora*  
59. Name of the seed: *Passiflora*  
60. Name of the leaf: *Passiflora*  
61. Name of the flower: *Passiflora*  
62. Name of the fruit: *Passiflora*  
63. Name of the seed: *Passiflora*  
64. Name of the leaf: *Passiflora*  
65. Name of the flower: *Passiflora*  
66. Name of the fruit: *Passiflora*  
67. Name of the seed: *Passiflora*  
68. Name of the leaf: *Passiflora*  
69. Name of the flower: *Passiflora*  
70. Name of the fruit: *Passiflora*  
71. Name of the seed: *Passiflora*  
72. Name of the leaf: *Passiflora*  
73. Name of the flower: *Passiflora*  
74. Name of the fruit: *Passiflora*  
75. Name of the seed: *Passiflora*  
76. Name of the leaf: *Passiflora*  
77. Name of the flower: *Passiflora*  
78. Name of the fruit: *Passiflora*  
79. Name of the seed: *Passiflora*  
80. Name of the leaf: *Passiflora*  
81. Name of the flower: *Passiflora*  
82. Name of the fruit: *Passiflora*  
83. Name of the seed: *Passiflora*  
84. Name of the leaf: *Passiflora*  
85. Name of the flower: *Passiflora*  
86. Name of the fruit: *Passiflora*  
87. Name of the seed: *Passiflora*  
88. Name of the leaf: *Passiflora*  
89. Name of the flower: *Passiflora*  
90. Name of the fruit: *Passiflora*  
91. Name of the seed: *Passiflora*  
92. Name of the leaf: *Passiflora*  
93. Name of the flower: *Passiflora*  
94. Name of the fruit: *Passiflora*  
95. Name of the seed: *Passiflora*  
96. Name of the leaf: *Passiflora*  
97. Name of the flower: *Passiflora*  
98. Name of the fruit: *Passiflora*  
99. Name of the seed: *Passiflora*  
100. Name of the leaf: *Passiflora*

TO HOSPITALS, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04606

|  |  |   |  |   |  |   |   |  |   |  |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Everett W. Brand</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 23, 1979</b>        |   |  | 2b. HOUR<br><b>10:10 pm</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 6, 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                         |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CONSULTANT</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>MONTGOMERY</b>                                       |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>819 DENNIS AVENUE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DANIEL J. BRAND</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA YOUNG</b>   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>577-05-1140</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MARGARET V. BRAND SAME AS 13 WIFE</b>                  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BACTEREMIC SHOCK</b><br><b>7854</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>GANGRENE, LEFT LEG.</b><br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 DAYS</b><br><b>18 DAYS</b> |  |   |  |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-9</b> 19 <b>79</b> , to <b>2-23</b> 19 <b>79</b> , that (I) <del>last</del> saw the deceased alive on <b>2-23</b> 19 <b>79</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>also</del> (did not) view the body after death.                     |  |   |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>Seruch T. Kimble</i>  |  |   |  |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2-24-79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SERUCH T. KIMBLE</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>9801 N. Georgia Avenue, Silver Spring, Md.</b>                     |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>2/27/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT. MD.</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1979</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCready</i>  |   |  |

10-01008

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 79-04607                                      |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO.                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lucille R. Brazier</b>  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 11 19 79</b> |  | 2b. HOUR<br><b>M</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 17, 20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61 YRS.</b>  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br><b>2 11 19 79</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                    |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>PG</b>   |  | 13c. CITY OR TOWN<br><b>Takoma Park</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  | 13e. STREET ADDRESS<br><b>6733 New Hampshire Avenue</b>                             |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Raiford</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucille Gomillion</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>143-20-7004</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mabeline B. McColl/daughter/same</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dissecting aortic aneurysm with rupture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |  |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |  |  |  | DATE SIGNED<br><b>2/12/79</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |  |  |  | ADDRESS<br><b>111 Penn St. Baltimore, MD.</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-16-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Va.</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John T. Rhines Co., 3015 12th St., N.E., D.C.</b>  |  |  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 16 1979</b>  |  |   |  |   |  |

7a-01007

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 79-04608<br>REG. NO.  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Cordell H. Brown</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>Feb 12 1979</b>  |  |
| 3. SEX <b>Male</b> RACE <b>White</b>   |  |  |  |  |  |  |  |  |  | 7b. HOUR <b>3:00 PM</b>   |  |
| 5. DATE OF BIRTH <b>Feb. 24, 1924</b> (LAST, MONTH, DAY) <b>54</b> YRS.  |  |  |  |  |  |  |  |  |  | 7c. DATE PRONOUNCED DEAD <b>Feb 16 1979</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>   |  |  |  |  |  |  |  |  |  | 7d. HOUR <b>2 AM</b>  |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher/Coach</b>                |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN RESIDENCE, GIVE RESIDENCE BEFORE ADMISSION) <b>13201 Ewood Lane</b>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>   |  |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montg.</b> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 13d. STREET ADDRESS <b>13201 Ewood Lane</b>   |  |
| 14. FATHER'S NAME (FIRST, MIDDLE, LAST) <b>Jack H. Brown</b>   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) <b>Jewell -- Howard</b>                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> 16b. SOCIAL SECURITY NO. <b>462-26-7563</b>  |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS <b>Patsy Brown, Same as # 13.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>4291 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                       |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. TITLE (SPECIFY) <b>Dep.</b> MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>Feb. 16 1979</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b> ADDRESS <b>Silver Spring, Montg. Co., Md.</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial/Transit</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE <b>2/18/79</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ft. Worth, Texas</b>                                   |  |
| 24. FUNERAL DIRECTOR NAME <b>Jos. Gawler's Sons, 5130 Wisconsin Ave., NW Washington, D.C. 20016</b>  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1979</b> 25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b> |  |



00810-0

Room

General

24

White

Male

Postmaster

U.S.A.

Texas

El Paso

1000

Teacher/Coach

1000

1000

Room

--

General

Room

U.S.A.

Jack

1000

1000

U.S.A.

Yon

1000

1000

1000

1000

1000

1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |         |  |   |  |        |  |   |  |                         |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                |  | 79-04609<br>REG. NO.                 |  |  |  |          |  |
|--|--|---------|--|---|--|--------|--|---|--|-------------------------|--|--|--|----------------|--|--------------------------------------|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  | FIRST   |  | MIDDLE |  | LAST  |  | 2a. DATE KNOWN OF DEATH |  | ESTIMATED  |  | MONTH          |  | DAY                                  |  | YEAR   |  | 7b. HOUR |  |
| Francis  |  |         |  | W.  |  | Brown  |  |   |  | Feb 26 1979             |  | 8:25   |  |                |  |                                      |  |  |  | P.M.     |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | MONTH  |  | DAY   |  | YEAR                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.                     |  | 2c. DATE PRONOUNCED DEAD                     |  | 7c. HOUR |  |
| M  |  | W       |  | Feb 27 20   |  | 58     |  | YRS.  |  |                         |  |  |  |                |  |                                      |  | Feb 26 1979                                  |  | 8:23     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |        |  | 8. MARRIED  |  |                         |  | NEVER MARRIED  |  |                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |          |  |
| Maryland   |  |         |  | USA   |  |        |  | WIDOWED   |  |                         |  | DIVORCED   |  |                |  | Montgomery                           |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        |  |   |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                      |  |                |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |          |  |
| Glen   |  |         |  | Mont. General Hosp  |  |        |  |   |  |                         |  | Govt. Ret.   |  |                |  | Govt.                                |  |  |  |          |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |        |  | 13c. CITY OR TOWN   |  |                         |  | 13d. INSIDE CITY LIMITS?   |  |                |  | 13e. STREET ADDRESS                  |  |  |  |          |  |
| Md   |  |         |  | Mont.   |  |        |  | Silver Spg  |  |                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |                |  | 607 Orchard Way                      |  |  |  |          |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME  |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| George F. Brown  |  |         |  | Elsie Thompson  |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.  |  |        |  | 17. INFORMANT   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| Yes  |  |         |  | WWII  |  |        |  | 212-14-3845   |  |                         |  | Thelma Brown, Silver Spring, Md.   |  |                |  | 20904                                |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>   |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| 4291   |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| (b) <u>Chronic Myocardial Dis.</u>   |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  | 11 yrs.                                      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| (c)  |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| None   |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |        |  |   |  |                         |  | 20. AUTOPSY?   |  |                |  |                                      |  |  |  |          |  |
| None   |  |         |  |   |  |        |  |   |  |                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |                |  |                                      |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY   |  |        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
|  |  |         |  | HOUR A.M. MONTH DAY YEAR  |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
|  |  |         |  | P.M. 19   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |        |  | 21f. LOCATION   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
|  |  |         |  |   |  |        |  | STREET CITY OR TOWN COUNTY STATE  |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |        |  | MEDICAL EXAMINER  |  |                         |  | DATE SIGNED  |  |                |  |                                      |  |  |  |          |  |
| John S. Rogers   |  |         |  | M.D. Dep.   |  |        |  |   |  |                         |  | Feb 26 1979  |  |                |  |                                      |  |  |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| John S. Rogers   |  |         |  | 1919 Seminary Rd. Silver Spring, Md.  |  |        |  |   |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |        |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                         |  | 23d. LOCATION  |  |                |  |                                      |  |  |  |          |  |
| Burial   |  |         |  | Mar. 2, 79  |  |        |  | George Washington   |  |                         |  | Adelphi, Prince George, Md.  |  |                |  |                                      |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  | 25a. DATE REC'D. BY REGISTRAR   |  |        |  | 25b. REGISTRAR'S SIGNATURE  |  |                         |  |  |  |                |  |                                      |  |  |  |          |  |
| Hines/Rinaldi  |  |         |  | 11800 New Hampshire Ave. Silver Spring, Md. 20904   |  |        |  | MAR 2 1979  |  |                         |  | History McCreedy   |  |                |  |                                      |  |  |  |          |  |

19-0600



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-04610  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul N. Brumbaugh  |  |  |  | Feb. 2 1979 330/AM   |  |   |  |
| 3. SEX MALE   |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 92   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 86 87 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.   |  |
| 10. CITY OR TOWN OF DEATH Gaithersburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Account Examiner   |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. (Ret.)   |  |
| 13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS 301-Russell Ave. Hager-Care Nursing Home   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Granville W. Brumbaugh  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Miller  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WWI  |  |   |  |
| 16b. SOCIAL SECURITY NO. 216-46-5547  |  | 17. INFORMANT H.B. Brumbaugh   |  | ADDRESS 3122-Manor Rd., Gaithersburg, Md.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c) <del>long</del><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 411-<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 6 mitral insufficiency |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/26 19 78, to Feb 2 19 79, that (I) (we) last saw the deceased alive on Jan 31 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE Alan R. Vinitsky   |  | DEGREE MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 2/2/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. VINITSKY  |  | 22e. ADDRESS 12105 DARNESTOWN RD. GAITHERSBURG, MD   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 2/5/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.  |  |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.  |  | ADDRESS Mt. Rainier, Md.   |  | 25a. DATE REC'D. BY REGISTRAR FEB 6 1979   |  | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy   |  |

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FEB 6 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR Home 2/15/79 rc<br>STATE REGISTRAR   |  |   |  |   | REG. NO. 79-04611  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Billy Louis Buck</u>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <u>2-12-79</u> 2b. HOUR <u>12:25</u> M  |  |  |  |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>July 28, 1925</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>54</u> <u>53</u> YRS.                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Georgia</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.                         |  |  |  |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Eng. Tech.</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Naval Surf. Wear</u>                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |
| 13a. STATE <u>Md.</u>   |  | 13b. COUNTY <u>Mont.</u>  |  | 13c. CITY OR TOWN <u>Gaithersburg</u>   |  | 13e. STREET ADDRESS <u>25121 Seneca View Court</u>                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <u>Raymond Clay Buck</u>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <u>Mildred Frances Knowles</u>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>Yes</u>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES) <u>WWII</u>  |  | 17. INFORMANT <u>Bonnie J. Buck</u>   |  | ADDRESS <u>Same as #13</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>2000 Suspected Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Histiocytic Lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>2000</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u><br><u>months</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> 19 <u>79</u> , to <u>2/12</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE <u>Stephen Newman</u> DEGREE <u>MD</u>   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED <u>2/12/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen Newman</u>   |  |   |  |   | 22e. ADDRESS <u>Mont. Village Ave. Gaithersburg, Md. 20760</u>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>Feb. 14, 1979</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Norbeck Memorial Park</u>   |  | 23d. LOCATION <u>Orney</u> <u>Mont.</u> <u>Co. Md.</u>                             |  | STATE <u>Md.</u>   |  |
| 24. FUNERAL DIRECTOR <u>Francis H. Barber Laytonsville, Md. 20760</u>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <u>FEB 15 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Pitney Kelso</u>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO. 79-04612 |
|---|--|---|--|---|--|--|--|--|--|-------------------|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Harold E. BURDETTE   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 24 1979   |  | 2b. HOUR<br>2:45P  |  |                   |
| 3 SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 24 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                       |  |  |  |                   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Army                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Military  |  |                   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>15400 Wentbridge Court  |  |                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Oliver   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rena Lloyd  |  |   |  |  |  |  |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>1941-1961   |  | 17. INFORMANT<br>Marie M. Burdette  |  | ADDRESS<br>See Item 13   |  |  |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the colon with diffuse abdominal carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |  |  |  |  |                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |                   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Feb. 22</u> , 19 <u>79</u> , to <u>Feb. 24</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |                   |
| 22b. SIGNATURE<br><u>R. J. M. Engler</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>Feb. 26, 1979  |  |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. J. M. ENGLER, M.D.  |  |   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |  |  |  |  |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>2/26/78  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia                              |  |  |  |                   |
| 24. FUNERAL DIRECTOR NAME<br>Tyson Wheeler Funeral Home Rockville, Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCready</u>  |  |  |  |                   |

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February 24 1978

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |   |  | REG. NO. 79-04613  |  |  |  |
|---|--|-------------------------|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Florence May Burnett</b>  |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br><b>Feb. 20, 1979</b> |  | 2b. HOUR<br>9:15 AM                    |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 1, 1894</b>   |  | 6. AGE (IN YEARS)<br>(AS BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>84</b>        |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Feb. 20 1979</b>   |  | 7d. HOUR<br>11:15 AM   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10213 Tyburn Terrace</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  |   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>10213 Tyburn Terrace</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>(unknown) Rezin</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Savannah Turner</b>       |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |  | 17. INFORMANT ADDRESS<br><b>Joseph A. Burnett-Same as items 13</b>            |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyper-tension Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Ball</b>  |  |                         |  | TITLE (SPECIFY)<br>M.D. <b>DePoty</b>   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>Feb 20, 1979</b><br>Md. |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John G. Ball</b>  |  |                         |  | ADDRESS<br><b>7936 Old Georgetown Rd. Beth.</b>   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>2/23/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, P. G., Md.</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. W. Chambers Co.,</b>  |  |                         |  |   |  | ADDRESS<br><b>Silver Spring, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>  |  |  |  |

79-01013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |  |   |  |  | REG. NO. 79-04614                                      |  |
|--|--|---|---|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MAGGIE Bush |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 31 1979 |  |  | 2b. HOUR<br>9 <sup>30</sup> M                          |  |
| 3 SEX<br>F   |  | 4 RACE<br>W   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 9 1877  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>100 YRS   |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>HARRISVILLE W.VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                      |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>GAITHERSBURG   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HERMAN WILSON HEALTH CT |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                 |   |  | 12b. KIND OF BUSINESS OR INDUSTRY        |  |  |
| 13a. STATE<br>MD   |  |   |   | 13b. COUNTY<br>MONTG   |  | 13c. CITY OR TOWN<br>GAITH   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>341 RUSSELL AVE                 |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>SALEM DUCKWORTH  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH ANN COXELEY  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |   | 16b. SOCIAL SECURITY NO.<br>577-07-1178D   |  | 17 (HOSPITAL RECORDS) ADDRESS<br>301 Russell Ave.,<br>Mrs. Beverly Craig Gaithersburg, Md. |   |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Biventricular pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>485-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Generalized arteriosclerosis</u>  |  |   |   |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1/63, 19 to 3/21/79, 19 that (I) (we) lost saw the deceased alive on 12/15/79, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.   |  |   |   |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Henry C. Scruggs   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |   | 22c. DATE SIGNED<br>3/22/79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HENRY C. SCRUGGS MD   |  |   |   | 22e. ADDRESS<br>5413 Cedar La. Bethesda Md.  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 26, '79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cemetery  |  | 23d. LOCATION CITY OR TOWN<br>Brentwood Prince George, Md.                                 |   | 23e. DATE REC'D. BY REGISTRAR<br>MAR 5 1979  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Gartner-Sandison F. H.  |  | 24b. ADDRESS<br>316 E. Diamond Ave., Gaithersburg, Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Henry C. Scruggs   |   |  |  |  |  |

44-38861-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04615

|   |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Hugh Patrick Caherty</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>February 28, 1979</b> |   |   | 2b. HOUR <b>4:54</b> AM  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>APRIL 30, 1894</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PLATE PRINTER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BUR. OF ENGRAV.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>MONTGOMERY</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13d. STREET ADDRESS<br><b>13200 GLENHILL ROAD</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN J. CAHERTY</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ANN MCGINN</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>184-07-5652</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>DEANE L. CAHERTY SAME AS 13 WIFE</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4146</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Pneumonia, Arteriosclerotic Heart Disease</b>   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/21</b> , 19 <b>79</b> , to <b>2/28</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/27/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Antonio G. Uy</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br><b>2/28/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANTONIO G. UY</b>   |  |   |  | 22e. ADDRESS<br><b>831 University Blvd E #25 Silver Spring, Md 20903</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/2/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WASHINGTON, D. C.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                     |  |  |  |
| 26. ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  |   |   |  |  |  |  |



20-04612

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |  |   |  |  |  |  |  | REG. NO. 79-04616  |  |   |  |  |  |  |  |
|---|--|---------------|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Emma Elizabeth Camp  |  |               |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>2-19 19 79              |  | 2b. HOUR<br>3:29 P  |  |  |  |  |  |
| 3. SEX<br>Fe-   |  | 4. RACE<br>W- |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-20-81   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>78 YRS.                  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2-19 19 79             |  | 2d. HOUR<br>3:29 P  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.               |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cashier/Bookkeeper  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>L.P. Stewart                                   |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  |               |  |   |  |  |  |  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Kensington   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3211 Fayette Road |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles A. Camp   |  |               |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Brockner |  |  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-01-6512  |  | 17. INFORMANT<br>sister<br>Ella C. White                       |  |  |  | ADDRESS<br>same as 13  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>4119<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |               |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |               |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>John B. Ball  |  |               |  | TITLE (SPECIFY)<br>M.D. DePoy   |  |  |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED<br>Feb 20, 1979   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John G. Ball, M.D.  |  |               |  | ADDRESS<br>7936 Old Georgetown Rd. Bethesda, Md.  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |               |  | 23b. DATE<br>Feb. 23, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery      |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland Baltimore Md. |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Francis J. Collins  |  |               |  | 25. DATE<br>FEB 22 1979   |  |  |  | 26. REGISTRAR'S SIGNATURE<br>R. G. Ball  |  |  |  |   |  |  |  |  |  |
| 500 University Blvd., W. Silver Spring, Md.   |  |               |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |

9-01616

John G. White, U.S.

Feb. 2, 1979 Cedar Hill Cemetery

Charles J. Collins

For information of the U.S. District Court, W.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |                            |   |  |
|---|--|---|--|--|---|--|----------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |   |  |                            |   |  |
| 29-04617<br>290029  |  |   |  |  |   |  |                            |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHN BENSON CARSON JR.</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEB 3 1979</b>                       |  | 2b. HOUR<br><b>0900 AM</b> |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASION</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>NOV 18 1924</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.  |                            | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>                                |                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NATIONAL NAVAL MEDICAL CTR</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>             |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US GOV'T</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |   |  |                            |   |  |
| 13a. STATE<br><b>VIRGINIA</b>   |  | 13b. COUNTY<br><b>FAIRFAX</b>   |  | 13c. CITY OR TOWN<br><b>BURKE</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET ADDRESS<br><b>5592 BLAKE HOUSE COURT</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN BENSON CARSON</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>HELEN ELIZABETH LOWDEN</b> |  |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>1942-1964 192-12-5150</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. SUSAN A. CARSON AS ABOVE</b>  |   |  |                            |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY FAILURE</b><br><br><b>1991</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADENOCARCINOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |  |   |  |                            |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                            |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |                            |   |  |
| 22b. SIGNATURE<br><i>J.K. O'Donnell</i>   |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>            |   |  |                            | 22c. DATE SIGNED<br><b>2/4/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J.K. O'DONNELL</b>  |  |   |  | 22e. ADDRESS<br><b>NNMC Bethesda Md 20014</b>  |   |  |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/5/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematorium</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                           |                            |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Demaine Funeral Home</b>  |  |   |  | ADDRESS<br><b>Alexandria, Va.</b>  |   | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 13 1979</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

MEDICAL CERTIFICATION

19-01017

FEB 2 1977

CAPTION

DEKOR

JOHN

NOV 18 1974

CAUCASIAN

MALE

MONTGOMERY

HE

PENNSYLVANIA

NATIONAL NAVAL MEDICAL CTR

BETHESDA

WEST BLAKE HOUSE COURT

X

BURRIT

FAIRFAX

VIRGINIA

LONDON

ELIZABETH

WELSH

CARSON

BENSON

1941

1 THE-1941-1942 MRS. SUSAN A. CARSON AS ABOVE

YES

PILGRIMAGE FAILURE

ADENOCARCINOMA

## CERTIFICATE OF DEATH

79-04618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |                              |  |   |  |                                     |  |                                |  |  |
|---|------------------------------|--|---|--|-------------------------------------|--|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR<br>11 30 AM           |  |  |
| Gene (WUS)  |                              | H.   | Castleberry   |  | February 11 1979                    |  |                                |  |  |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |  |
| Male  | Caucasian                    |  | April 9, 1898   |  | 80 YRS.                             |  |                                |  |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                  |  |                                |  |  |
| Uia, Arkansas   | U.S.A.                       |  |   |  | Montgomery Md.                      |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |  |  |
| Silver Spring, Md.  |                              | 15006 Haslemere Ct.  |   | Real Estate BROKER   |                                     |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN  |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER                       |  |
| Md.   |                              | Montgomery   |   | Silver Spring  |                                     |  |                                | 15006 Haslemere Ct.                          |  |
| 14. FATHER'S NAME   |                              | 15. MOTHER'S MAIDEN NAME   |   |  |                                     |  |                                |  |  |
| First Middle Last   |                              | First Middle Last  |   |  |                                     |  |                                |  |  |
| Elisha M. Castleberry   |                              | Elizabeth Derrick  |   |  |                                     |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                     | Address  |                                |  |  |
| no  |                              | 577-09-9303  |   | Virginia Castleberry   |                                     | (same)   |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |  |   |  |                                     |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Widespread metastatic carcinoma</u>  |                              |  |   |  |                                     |  |                                | 3 years                                      |  |
| 1539 DUE TO, OR AS A CONSEQUENCE OF <u>Primary probably colon</u>   |                              |  |   |  |                                     |  |                                |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                              |  |   |  |                                     |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |                              |  |   |  |                                     |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |                              |  |   |  |                                     |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |  |   |  |                                     |  |                                |  |  |
| <u>Cancer of the bladder diagnosed Nov 1975</u>   |                              |  |   |  |                                     |  |                                |  |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |  |  |
| None  |                              |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |                                     |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)        |                                     |  |                                |  |  |
|   |                              |  |   |  |                                     |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.   |                                     | City or Town   |                                | State  |  |
|   |                              |  |   |  |                                     |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 June</u> , 1976, to <u>11 Feb</u> , 1979, that (I) <u>(was)</u> last saw the deceased alive on <u>1 Feb</u> , 1979, and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(was)</u> <u>(did)</u> (did not) view the body after death. <u>My nurse did view the body.</u> |                              |  |   |  |                                     |  |                                |  |  |
| 22b. SIGNATURE<br><u>Gustavo S. Belaval, M.D.</u>   |                              |  |   | 22c. DATE SIGNED<br><u>11 Feb 79</u>   |                                     |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>GUSTAVO S. BELAVAI</u>   |                              |  |   | 22e. ADDRESS<br><u>Leisure World Medical Center</u><br><u>Silver Spring, Md 20906</u>  |                                     |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION (City or Town) (County) (State)  |                                |  |  |
| CREMATION   |                              | Feb. 12, 1979  |   | METROPOLITAN CREMATORY   |                                     | ALEXANDRIA ARLFAA  |                                | VA.  |  |
| 24. FUNERAL DIRECTOR <u>FRANCIS J. COLLINS</u> ADDRESS<br><u>500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD</u>   |                              |  |   | 25a. REC'D BY REGISTRAR<br><u>FEB 13 1979</u>  |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Dorothy McCready</u>  |                                |  |  |

81340-25



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-04619<br>290095  |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   | 20. DATE OF DEATH MONTH DAY YEAR   |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ALFRED ARCHIE CHALMERS</b>   |  |   | FEBRUARY 16, 1979  |  | 2b. HOUR<br>0725AM  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCTOBER 22 1916</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS   | IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.                            |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KANSAS</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NATIONAL NAVAL MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Military</b>                                 |   |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>PRINCE GEORGE</b>  | 13c. CITY OR TOWN<br><b>OXON HILL</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JESSE Monroe CHALMERS</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>HAZEL SMITH</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WWII</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>4499-07-9528</b>  |  |   |
| 17. INFORMANT ADDRESS<br><b>WANETA CHALMERS 9904 INDIAN QUEEN</b>   |  |   | 17. INFORMANT ADDRESS<br><b>9904 INDIAN QUEEN RD</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>DISSEMINATED OAT CELL CARCINOMA</b> POINT RD OXON HILL MD<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that I (this hospital) attended the deceased from <b>04 FEBRUARY 19 79</b> to <b>16 FEBRUARY 19 79</b> , that I (we) lost<br>saw the deceased alive on <b>16 FEBRUARY 19 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above I (we) (did) (do) not view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br><i>Marina N. Vernalis</i>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>16 FEB 79</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. VERNALIS MD</b>  |  |   | 22e. ADDRESS<br><b>NNMC BETHESDA MD</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>2/17/79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                   |   |
| 24. FUNERAL DIRECTOR'S NAME<br><b>LEE FUNERAL HOME CLINTON, MD</b>  |  | 25a. DATE RECORDED BY REGISTRAR<br><b>FEB 27 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James H. Brady</i>                                  |   |

19-04819



RECEIVED  
FEBRUARY 11 1971  
OFFICE OF THE  
DIRECTOR  
NATIONAL ARCHIVES  
COLLIERIE  
WASHINGTON, D.C.  
20540  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |  |  | 79-04620 |  |
|--|--|---|---|---|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |  |  |  |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>J. KENTON CHAPMAN  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 8 1979  |  |  | 2b. HOUR<br>7:50A <sub>M</sub>   |  |          |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 23 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mississippi   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEARS)<br>Attorney                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Law                         |  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE D. C. 13b. COUNTY --- 13c. CITY OR TOWN Washington   |  |   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3803 Southern Ave. S. E. Apt. / 102       |  |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Harrison Chapman   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mai Dawn Samuel                                |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>WW 11 577 42 7560  |  | 17. INFORMANT ADDRESS<br>Mrs. Frances Chapman See item 13        |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic lung carcinoma<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |   |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |          |  |
| 22a. I certify that (I (this hospital) attended the deceased from January 25, 1979, to February 8, 1979, that I (we) lost saw the deceased alive on February 8, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br>Scott M. Whiddon, M.D.   |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>Feb. 8, 1979   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Scott M. Whiddon, M.D.  |  |   |   |   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Feb. 13, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Columbia, Mississippi |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>ROBT. A. Pumphrey Funeral Home Bethesda, Md.   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>Feb 13 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |          |  |

BP

SECTION 1

1. Name of the person or entity: [illegible]

2. Address: [illegible]

3. City: [illegible]

4. State: [illegible]

5. Zip: [illegible]

6. Date of birth: [illegible]

7. Date of death: [illegible]

8. Date of entry: [illegible]

9. Date of exit: [illegible]

10. Date of departure: [illegible]

11. Date of arrival: [illegible]

12. Date of departure: [illegible]

13. Date of arrival: [illegible]

14. Date of departure: [illegible]

15. Date of arrival: [illegible]

16. Date of departure: [illegible]

17. Date of arrival: [illegible]

18. Date of departure: [illegible]

19. Date of arrival: [illegible]

20. Date of departure: [illegible]

21. Date of arrival: [illegible]

22. Date of departure: [illegible]

23. Date of arrival: [illegible]

24. Date of departure: [illegible]

25. Date of arrival: [illegible]

26. Date of departure: [illegible]

27. Date of arrival: [illegible]

28. Date of departure: [illegible]

29. Date of arrival: [illegible]

30. Date of departure: [illegible]

31. Date of arrival: [illegible]

32. Date of departure: [illegible]

33. Date of arrival: [illegible]

34. Date of departure: [illegible]

35. Date of arrival: [illegible]

36. Date of departure: [illegible]

37. Date of arrival: [illegible]

38. Date of departure: [illegible]

39. Date of arrival: [illegible]

40. Date of departure: [illegible]

41. Date of arrival: [illegible]

42. Date of departure: [illegible]

43. Date of arrival: [illegible]

44. Date of departure: [illegible]

45. Date of arrival: [illegible]

46. Date of departure: [illegible]

47. Date of arrival: [illegible]

48. Date of departure: [illegible]

49. Date of arrival: [illegible]

50. Date of departure: [illegible]

51. Date of arrival: [illegible]

52. Date of departure: [illegible]

53. Date of arrival: [illegible]

54. Date of departure: [illegible]

55. Date of arrival: [illegible]

56. Date of departure: [illegible]

57. Date of arrival: [illegible]

58. Date of departure: [illegible]

59. Date of arrival: [illegible]

60. Date of departure: [illegible]

61. Date of arrival: [illegible]

62. Date of departure: [illegible]

63. Date of arrival: [illegible]

64. Date of departure: [illegible]

65. Date of arrival: [illegible]

66. Date of departure: [illegible]

67. Date of arrival: [illegible]

68. Date of departure: [illegible]

69. Date of arrival: [illegible]

70. Date of departure: [illegible]

71. Date of arrival: [illegible]

72. Date of departure: [illegible]

73. Date of arrival: [illegible]

74. Date of departure: [illegible]

75. Date of arrival: [illegible]

76. Date of departure: [illegible]

77. Date of arrival: [illegible]

78. Date of departure: [illegible]

79. Date of arrival: [illegible]

80. Date of departure: [illegible]

81. Date of arrival: [illegible]

82. Date of departure: [illegible]

83. Date of arrival: [illegible]

84. Date of departure: [illegible]

85. Date of arrival: [illegible]

86. Date of departure: [illegible]

87. Date of arrival: [illegible]

88. Date of departure: [illegible]

89. Date of arrival: [illegible]

90. Date of departure: [illegible]

91. Date of arrival: [illegible]

92. Date of departure: [illegible]

93. Date of arrival: [illegible]

94. Date of departure: [illegible]

95. Date of arrival: [illegible]

96. Date of departure: [illegible]

97. Date of arrival: [illegible]

98. Date of departure: [illegible]

99. Date of arrival: [illegible]

100. Date of departure: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |   |   | 79-04621                                     |  |
|---|--|---|--|---|---|--|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |   |  |  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES WILLIAM CHAPPLE SR.</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 6, 1979</b>        |  |  | 2b. HOUR<br><b>12:25 PM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 11, 1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FOREMAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PEPCO</b>   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |  |   | 13b. COUNTY<br><b>PRINCE GEO.</b>                                     |  | 13c. CITY OR TOWN<br><b>TAKOMA PARK</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES CHAPPLE</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IRENE STREEKS</b> |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-09-6028</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>LOUISE D. CHAPPLE SAME AS 13 WIFE</b>  |   |  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure secondary to</b><br><b>1439</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>disseminated alveolar carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-16</b> , 19 <b>79</b> , to <b>2-6</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2/6/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Boris Rabkin</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |   |  |  |   |   | 22c. DATE SIGNED                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BORIS RABKIN MD.</b>  |  |   |  |   | 22e. ADDRESS<br><b>1019 University Blvd East Silver Spring</b>        |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/9/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BRENTWOOD PRI GEO MD.</b> |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1979</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                      |   |   |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |  |   |   |  |  |   |   |  |  |

BP

19-04651

|                       |                      |                                  |                  |      |
|-----------------------|----------------------|----------------------------------|------------------|------|
| 12-22 PM              | ST. FEBRUARY 6, 1979 | WILLIAM                          | WHITE            | MALE |
| 73                    | FEB 11 1908          | U.S.A.                           | WASHINGTON, D.C. |      |
| WASHINGTON            | XXV                  | WASHINGTON ADVENTIST HOSPITAL    | TAKOMA PARK      |      |
| FOURTH                | XX                   | MARYLAND BRIDGE GTO. TAKOMA PARK |                  |      |
| 6100 KENNEDICK AVENUE |                      |                                  |                  |      |
| STREET                | TRINE                | CHARLIE                          | JAMES            |      |
| WIFE                  | LOUISE B. CHARLIE    | 577-00-0000                      | NO               |      |
| DATE AS IS            |                      |                                  |                  |      |

200 UNIT. ELVIS, W. SILVER SPRING, MD. 20901  
FRANCIS J. COLLINS  
2/9/79  
FT. LINCOLN  
BREMERS  
PIL GEO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| 1. FOR STATE REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO. 79-04622  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Richard Earl CHEW   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 27 1979                        |  | 2b. HOUR<br>330A M  |
| 3 SEX<br>Male  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 15 1960   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>18 YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Navy |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>New Jersey   |   |   | 13b. COUNTY<br>Hudson   | 13c. CITY OR TOWN<br>Kearny  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Richard E. Chew   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Christina Hahn                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>1978-79   |   | 17. INFORMANT ADDRESS<br>Navy Records/Richard Chew, father                           |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest - Insufficiency</u><br>1917 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain stem dysfunction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pontine Glioma</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hour</u><br><u>5 mos</u><br><u>6 mos</u> |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pulmonary emboli - Thrombo phlebitis</u>   |   |   |   |  |   |
| 19a. DATE OF OPERATION<br>11/24/78   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>parabrainsstem tumor  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 9</u> , 19 <u>78</u> , to <u>Feb. 27</u> , 19 <u>78</u> , that (I) (we) lost <u>above</u> the deceased alive on <u>Feb. 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><u>Ronald P. Hantman</u>   |   | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br>27 Feb. 1979   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RONALD P. HANTMAN   |   | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>2 Mar 79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery                            |   |
| 23d. LOCATION CITY OR TOWN<br>North Arlington  |   | COUNTY<br>N.J.  |   | STATE  |   |
| 24. FUNERAL DIRECTOR NAME<br>Marshall Funeral Home   |   | ADDRESS<br>Washington, D.C.   |   | 25. DATE REC'D. BY REGISTRAR<br>MAR 2 1979   |   |
| 26. REGISTRAR'S SIGNATURE<br><u>Anthony McCready</u>   |   |   |   |  |   |



79-04622

February 27, 1970

Internal Mail

Feb. 12, 1960

General

File

Continuation

NY

New York

U.S. Navy

National Naval Medical Center

70 Island Street

X

Warner

New Jersey Division

John

Continuation

Chase

NY

New York

U.S. Navy Records Administration

1-70-20

File

Department of Defense

Department of Defense

Department of Defense

Department of Defense

Department of Defense

File

February 27, 1970

NY

NY

NY

Feb. 27, 1970

Department of Defense

National Naval Medical Center, Bethesda, Md.

U.S. Navy (New York Division)

National Naval Medical Center, Bethesda, Md.

**NOTES TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **RETURN TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04623

|   |  |                  |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|---|--|------------------|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |                  |  |   |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |  |  |  |  | REG. NO. 79-04623   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elwood H. Chisolm  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>Feb. 20, 1979                              |  |   |  |   |  |  |  |  |  | 2b. HOUR<br>9:00 AM |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Negro |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 1, 1916   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>63 YRS                |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD<br>Feb 20, 1979  |  | 2d. HOUR<br>9:01 AM   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lawyer            |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>University   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  |                  |  |   |  |   |  |   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9822 Georgia Ave. |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles S. Chisolm, Sr.   |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Erlena V. Holmes                  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>578-16-0837   |  |   |  | 17. INFORMANT<br>Ann L. Chisolm, Wife   |  |  |  | ADDRESS<br>SAA  |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4291 Acute Myocardial Dis.<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Chronic Myocardial Dis. yrs.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |   |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None   |  |                  |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>None  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                  |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>John S. Rogers  |  |                  |  | TITLE (SPECIFY)<br>M.D. Dep.  |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>Feb. 20, 1979  |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers  |  |                  |  | ADDRESS<br>1919 Seminary Rd., Sil. Spr., Md.  |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>2/24/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial Cem. |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland                   |  |   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John F. Balala  |  |                  |  | ADDRESS<br>7400 Ga., Ave., N. W.<br>Washington, D. C. 20012   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1979  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |

10-04853

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |  |   |   |  |   | REG. NO. 79-04624  |  |
|---|--|---|---|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CATHERINE E CHURCHMAN |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 12, 1979 |  |   | 2b. HOUR<br>5:25AM   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>white   |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>June 27, 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Chevy Chase, Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHEVY CHASE Nsg & CONV. CENT. |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Housewife                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>2214 Colston Dr. #101   |   |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Montgomery   |   | 13c. CITY OR TOWN<br>Silver Spring   |  |   |   |  |   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Cochran  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katherine Parker   |  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220-54-1149   |   | 17 INFORMANT ADDRESS<br>2214 Colston Dr. #101 Sil. Sp. Md.   |  | Charlotte C. Hamilton-daughter  |   | 20910  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4409 Cardiac-pulmonary failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) aspiration pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis                        |  |   |   |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hrs<br>24 hrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26, 1979, to 2/12, 1979, that (I) (we) last saw the deceased alive on 2/11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>John O. Allin M.D.  |  |   |   | DEGREE<br>M.D.   |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/12/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John O. Allin M.D.   |  |   |   | 22e. ADDRESS<br>8218 Wisconsin Ave. Bethesda, Md.  |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>2-16-79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, D.C.                                     |   |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>P. J. McCreedy   |   |  |  |

42-01054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | REG. NO.<br>79-04625                                  |  |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILLIE A. CLARK</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-19-79</b>   |  | 2b. HOUR<br><b>4:00 P</b> M                           |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6-2-1888</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>                                    |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>         |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>College Pk.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7409 - Baylor Avenue</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Askins</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine (Unknown)</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-52-8294</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Vanda C. Reid 8763-Contee Rd. Laurel, Md.</b>                     |  |  |  |   |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b>  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |
| (b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |  |  |   |  |  |  | <b>3 DAYS</b>   |  |
| (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |  |   |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 19 78</b> , to <b>19 FEB 19 79</b> , that (we) lost saw the deceased alive on <b>18 FEB 19 79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Walter E. Goetz MD</b>   |  |   |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>20 FEB 79</b>                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER E. GOOZH MD</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>2209 SHOREFIELD RD WHEATON MD</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-23-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Pr. Geo. Md.</b>                      |  |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Nalley's F.H.Inc.</b>   |  |   |  |  |  | ADDRESS<br><b>Mt. Rainier, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB - 6 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b> |  |

MEDICAL CERTIFICATION

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7104





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | REG. NO. 79-04626   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Elizabeth R. Clawson</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>2-23-79</i>                                |   | 2b. HOUR<br><i>3:50 P.M.</i>   |
| 3 SEX<br><i>Female</i>  | 4 RACE<br><i>W</i>   | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>2-23-97</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>82</i> YRS.                                 |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penna.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                     |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Rockville</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Collingswood Nursing Home</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>N/A</i>  |
| 13a. STATE<br><i>Md.</i>  |  |   | 13b. COUNTY<br><i>Montgomery</i>  | 13c. CITY OR TOWN<br><i>Rockville</i>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>George P. Weaver</i>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br><i>Elizabeth A. Richards</i>             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>188-32-0407D</i>   | 17. INFORMANT ADDRESS<br><i>9605 Trail Ridge Terr. Potomac, Md. 20854</i>         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma</i><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr.</i>  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Bilateral lung involvement &amp; bone involvement.</i>  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>1629</i>   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) <del>who</del> <i>who</i> hospital attended the deceased from <i>Sept</i> 19 <i>78</i> to <i>23 Feb</i> 19 <i>79</i> , that (I) <del>was</del> <i>was</i> last saw the deceased alive on <i>21 Feb</i> 19 <i>79</i> , and that in (my) <del>best</del> <i>best</i> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> <i>have</i> (did) <del>not</del> <i>not</i> view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><i>Donald E. Dillon M.D.</i>  |  | DEGREE  |   | 22c. DATE SIGNED<br><i>23 Feb 79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Donald E. Dillon, M.D.</i>  |  | 22e. ADDRESS<br><i>1811 Pr. Philip Dr Olney, Md 20832</i>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>2-26-79</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Clair Cemetery</i>                   |  |
| 23d. LOCATION CITY OR TOWN<br><i>Greensburg</i>   |  | COUNTY<br><i>Westmoreland</i>   |   | STATE<br><i>Pa.</i>   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Tyson Wheeler F. H. Rockville, Md.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 2 1979</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey McBrady</i>                              |  |
| 24. FUNERAL HOME<br><i>Sollon Funeral Home 30 E. College St. Cannonsburg, Pa.</i>   |  |   |   |   |  |

10-01050



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |   |   | REG. NO. 79-04627  |  |
|--|--|---|---|---|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   |  |   |  |   |   | 79-04627   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Andrew Alfred Coccia  |  |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 2/6 1979   |  | 2b. HOUR<br>M   |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 16 1913              |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS<br>65  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2/6 1979                                |   | 7d. HOUR<br>A. M. 4:10   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>15104 Sunflower Court |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gift Shop                |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |   |  |   |   |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery                                       |   | 13c. CITY OR TOWN<br>Rockville                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>15104 Sunflower Court  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ferdinand Coccia   |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Celestina Ruggiero   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII |   | 17. INFORMANT<br>Nancy Coccia, Wife, Same as item 13.           |  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u><br>4591<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None  |  |   |   |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>None   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?               |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                 |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)     |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |   |   |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>John S. Rogers, M.D.   |  |   |   | TITLE (SPECIFY)<br>Deputy MEDICAL EXAMINER                      |  |   |  | DATE SIGNED<br>2/6/79   |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers, M.D.   |  |   |   | ADDRESS<br>1919 Seminary Road<br>Silver Spring, Montgomery, Md. |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |   | 23b. DATE<br>2/9/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery   |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOSEPH CAWLER'S SONS INC.<br>ADDRESS<br>8120 WISD. AVE., H. W. WASH., D. C. 20518  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1979                    |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |  |  |

79-01627

July 10 1953

New York

U.S.

Gift Shop

Hammer

Hammer

Celestina

Coccol

Termination

Henry Coccol, wife, Anne as item 15.

79-01627

NY

Yes

100% of 100% of 100%

100%

100% of 100% of 100%

Gift of Heaven Cemetery, Silver Spring, Maryland.

79-01627

NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | REG. NO. 79-04628  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                              |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  | 2b. HOUR  |  |  |
| LOWRY N COE  |  |  | 2-27-79 3P M  |  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR MONTHS DAYS   |  |
| Male   | White  | Oct. 8 1896  | 82 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Maryland   | U.S.A.   |  | Montgomery MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Rockville  | Potomac Valley Nursing Home  |  | Attorney  |  | Law  |
| 13a. STATE   |  |  | 13b. CITY OR TOWN   | 13c. STREET ADDRESS  |  |
| Maryland   |  |  | Montgomery  | Rockville  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                    |  |  |
| B. A. Coe  |  |  | Mary Jane Sewell  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |  |  |
| Yes  |  | WW1  | Son Md  |  |  |
|  |  | 213-38-2640  | Lowry N Coe, Jr. 6208 Meadow Ct., Rockville,                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| 2030 Congestive failure  |  |  |   |  | 6 hours  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |   |  | 3 years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1959 to 27 Feb 1979, that (I) (we) lost saw the deceased alive on 25 Feb 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| Herbert Martyn Jr.   |  | MD   |   | 27 Feb 79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| HERBERT MARTYN JR.   |  | 6917 Arlington Rd Bethesda Md  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |
| Burial   |  | 3/2/1979   | Parklawn Memorial Park  |  | Rockville, Maryland.   |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| JOSEPH GAWLER'S SONS INC.  |  | MAR 2 1979   |   | Joseph Gawler  |  |
|  |  | 3139 WISG. AVE., N. W. WASH., D. C. 20516  |   |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                       |  |  |  |  |  |   |  |                  |  | REG. NO. 79-04629   |  |  |  |  |  |  |  |
|--|--|-----------------------|--|--|--|--|--|---|--|------------------|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Frances My Conde</i>   |  |                       |  |  |  |  |  |   |  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><i>Feb 23 1979</i> |  | 2b. HOUR<br><i>3:30</i> M                    |  |  |  |  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>Bik</i> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>April 1 1928</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>52</i> |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><i>Feb 23 1979</i>  |  | 2d. HOUR<br><i>3:30</i> M                    |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Unkn.</i>  |  |                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>Unkn.</i>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery MD.</i>   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Tak Park</i>   |  |                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Wash. Advent Hosp</i> |  |  |  |   |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Unkn.</i>                                 |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                       |  |  |  |  |  |   |  |                  |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><i>Md.</i>   |  |                       |  | 13b. COUNTY<br><i>Mont</i>   |  |  |  | 13c. CITY OR TOWN<br><i>Tak Park</i>  |  |                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |  |  | 13e. STREET ADDRESS<br><i>7600 Maple Ave</i>     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unkn.</i>   |  |                       |  |  |  |  |  |   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unkn.</i>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  |                       |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>579-38-7507</i>       |  |   |  |                  |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Inf.</i><br>4291 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) <i>Chronic Congestive Failure and Renal Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                       |  |  |  |  |  |   |  |                  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><i>None</i>   |  |                       |  |  |  |  |  |   |  |                  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |  |                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |                  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |                  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                  |  |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                       |  |  |  |  |  |   |  |                  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   |  |                       |  | TITLE (SPECIFY)<br>M.D. Reg. MEDICAL EXAMINER  |  |  |  |   |  |                  |  | DATE SIGNED<br><i>Feb 23 1979</i>   |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                       |  | ADDRESS  |  |  |  |   |  |                  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i>   |  |                       |  | 23b. DATE<br><i>Mon 2/26/79</i>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Anatomy Board Balto., Md.</i>   |  |                       |  |  |  |  |  |   |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 27 1979</i>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO. 79-04630 |  |
|--|--|--|--|---|--|--|--|--|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Correll Elisha Cook   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 11 1979  |  | 2b. HOUR<br>9:30 AM  |  |                   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 23 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Alfred Station N.Y.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hosp |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Capt. Forest Co. Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY CITY OR TOWN<br>Md. Montg. Burtonsville  |  |  |  |   |  | 13d. INSIDE CITY LIMITED<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS  |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>193-01-4870   |  | 17. INFORMANT ADDRESS<br>La Rue Cook (son) 3815-Belta Linn Dr. Hunting Neck  |  |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Respiratory Failure<br>5829<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Pulmonary Edema<br>(c) Chronic Renal Failure<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>2 days<br>6 weeks |  |  |  |   |  |  |  |  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>Pulmonary Embolus;  |  |  |  |   |  |  |  |  |  |                   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29, 1979, to 2/11, 1979, that (I) (we) lost saw the deceased alive on 2/11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |                   |  |
| 22b. SIGNATURE<br>Alfred Munzer  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/11/79  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alfred Munzer, M.D.   |  |  |  |   |  | 22e. ADDRESS<br>7600 Carroll Ave Takoma Park Md.   |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |                   |  |
| Burial   |  | Feb. 5-1979  |  | Maple Wood  |  | Takoma Park Co - Alfred N.Y.   |  |  |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.A. Walters, Takoma FH, Inc. Wash, D.C. 20012   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 6 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCready   |  |  |  |                   |  |

03340-27

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04631

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |   |   |  |
|--|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY -- COTSONIS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 16, 1979</b>                   |   |  | 2b. HOUR<br><b>11:30P</b>  |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 29, 1883</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                         |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Painting Contractor</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander -- Cotsonis</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Francesca -- Tartari</b>  |   |  | 13e. STREET ADDRESS<br><b>1309 Midwood Place</b>                                     |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-46-0098</b> |   | 17. INFORMANT<br><b>Daughter</b><br>ADDRESS<br><b>Mary C. Seymore, 6709 Michaels Dr., Beth., Md.</b>   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Ca. 7 DAYS</b><br><b>UNCERTAIN</b><br><b>UNCERTAIN</b>                  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>FEB. 14, 1979</b> to <b>FEB. 16, 1979</b> , that (1) (time) last<br>saw the deceased alive on <b>FEB. 16, 1979</b> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (time) (did not) view the body after death.  |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Lawrence D. Marcus, MD</b>  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>2/17/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence D. Marcus</b>   |  |   |   |   | 22e. ADDRESS<br><b>1111 Spring St., Silver Spring, Md.</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2/21/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Maryland</b>                        |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph Gawler's Sons, Washington, D.C. 20016</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McBrady</b>  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

13340-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 1606704632                          |
|--|--|---|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ELAINE RAY CUENIN  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 13 1979                             |  | 2b. HOUR<br>0210am   |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JANUARY 25 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>59                                       |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>massachusetts  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                            |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NATIONAL NAVAL MEDICAL CENTER |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary        |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Pvt Industry   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE VIRGINIA 13b. COUNTY ALEXANDRIA 13c. CITY OR TOWN ALEXANDRIA 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  | 13e STREET ADDRESS<br>6101 EDSALL RD #1802                                       |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>RUPERT S. RAY  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARGUERITE R. O'LOUGHLIN  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  | (IF YES, GIVE WAR OR DATES)<br>WW II  |  | 16b SOCIAL SECURITY NO.<br>023 14 9539   |  | 17 INFORMANT ADDRESS<br>WALTER H. CUENIN 6101 EDSALL RD#1802                     |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).<br>1889 UREMIA<br>DUE TO, OR AS A CONSEQUENCE OF (b).<br>DISSEMINATED TRANSITIONAL CELL CARCINOMA OF THE BLADDER<br>DUE TO, OR AS A CONSEQUENCE OF (c).                                     |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).   |  |   |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from 16 JANUARY 19 79 to 13 FEBRUARY 79, that I (we) last saw the deceased alive on 13 FEBRUARY 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>P. Albert MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br>13FEB79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. ALBERT MD  |  |   |  | 22e. ADDRESS<br>NNMC BETHESDA, MD. 20014   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>13FEB79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NATIONAL   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ARLINGTON VIRGINIA                    |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br>DEMAINE FUNERAL HOME ANNADALE, VA.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>15FEB79   |  | 25b. REGISTRAR'S SIGNATURE<br>History McCreedy                                   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THOMAS G. WARD 1/4/79  
 7408 CARROLL AVE. FB  
 TAKOMA PARK MD 3-59538-6

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO. 79-04633

|  |  |   |   |   |   |  |   |  |  |
|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOIS S. CUNNINGHAM</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>6</b> YEAR <b>79</b>                             |   |   | 2b. HOUR<br><b>4 A</b> M   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>4</b> YEAR <b>1888</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Clerk</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Veterans Admn.</b>   |  |
| 13a. STATE<br><b>Wash, D.C.</b>  |  |   | 13b. COUNTY<br><b>Wash, D.C.</b>  |   | 13c. CITY OR TOWN<br><b>Wash, D.C.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>W.</b> LAST <b>Cunningham</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mollie</b> MIDDLE <b>Hammrick</b> LAST <b>Hammrick</b> |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>578-54-9523</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Fae Mayo, 4904 Olive Grove Ln, Va. Beach, Va</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA, COLOON</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>4 years</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> |  |   |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>Sept 28</b> , 19 <b>79</b> , to <b>2/6</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Thos G. Ward</b>  |  |   | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/6/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thos G. Ward</b>   |  |   | 22e. ADDRESS<br><b>6116 Robinwood, Bethesda, Md, 20032</b>                                  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>2/8/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Princess Anne Crematorium</b>          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Virginia Beach, Virginia</b>                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>David L. Smith</b> ADDRESS   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1979</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>  |   |  |  |

BP

33040-07



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 270344 79-04634   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOAN GAY DAUGHERTY  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 09 1979  |   |  | 2b. HOUR<br>0400AM  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 10 1932  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CONNECTICUT   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NATIONAL NAVAL MEDICAL CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESLERK                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SALES  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>ROCKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1014 BRICE ROAD  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY W HANSEN   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET FIAK   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>454-30-6059  |  | ADDRESS<br>Rockville, Md.<br>RICHARD L DAUGHERTY 1014 BRICE RD                                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) DISSEMINATED MALIGNANT MELANOMA<br>1729<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from 05 FEBRUARY 19 79, to 09 FEBRUARY 19 79, that (we) last saw the deceased alive on 09 FEBRUARY 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>J. Curran  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>09 FEB 79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. CURRAN MD  |  |  |  |   | 22e. ADDRESS<br>NNMC BETHESDA, MD. 20014   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>Feb. 13, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>National Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Chattanooga TN                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CAPITOL FUNERAL SERVICES   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>FEB 14 1979  |   |  |   |  |
| FAIRFAX, VA.   |  |  |  |   |  |   |  |   |  |

10-01034

Rep. 13, 1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 79-04635        |     |  |          |
|---|--|--|--|--|--|--|--|--|--|-----------------|-----|--|----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |  |  |  |  |                 |     |  |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH           | DAY | YEAR   | 2b. HOUR |
| Barbara   |  | THERESA  |  | Deckard  |  |  |  | 2  |  | 22              | 79  | 147  |          |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                          |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS |     |  |          |
| female  |  | WHITE  |  | 10 2 92  |  | 86 YRS.  |  | MONTHS   |  | DAYS            |     | HOURS MIN                                    |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |  |  |                 |     |  |          |
| MARYLAND  |  | U.S.A.   |  |  |  | MONTGOMERY   |  |  |  |                 |     | MD.  |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |                 |     |  |          |
| TAKOMA PARK   |  | WASHINGTON ADVENTIST HOSPITAL  |  | HOUSEWIFE  |  |  |  |  |  |                 |     |  |          |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS  |  |                 |     |  |          |
| MARYLAND  |  | MONTGOMERY   |  | SILVER SPRING  |  | X NO <input type="checkbox"/>                            |  | 100 EAST WAYNE AVENUE  |  |                 |     |  |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                 |     |  |          |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |  |  |  |  |                 |     |  |          |
| MICHAEL   |  | HEIM   |  | MARY   |  | KREIGER  |  |  |  |                 |     |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |  |  |  |  |                 |     |  |          |
| NO  |  | 220-48-9106  |  | DAUGHTER   |  | MARIE K. O'BRIEN, P.O. BOX 615, SILVER SP., MD.          |  |  |  |                 |     |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |                 |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| IMMEDIATE CAUSE (a) <u>Acute Respiratory arrest</u>   |  |  |  |  |  |  |  |  |  |                 |     |  |          |
| 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Irreversible Brain Stem CVA</u>  |  |  |  |  |  |  |  |  |  |                 |     |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>acute congestive Heart Failure</u>   |  |  |  |  |  |  |  |  |  |                 |     |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |                 |     |  |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                 |     |  |          |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                 |     |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |                 |     |  |          |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |                 |     |  |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY   |  | STATE           |     |  |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  |  |  |  |  |                 |     |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-10-79, 19____, to 2-22-79, 19____, that (we) lost saw the deceased alive on 2-22-79, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                 |     |  |          |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |  |  |                 |     |  |          |
| Charles L. Franklin Jr  |  | MD   |  | 2-23-79  |  |  |  |  |  |                 |     |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |  |  |                 |     |  |          |
| Charles L. Franklin Jr  |  | 11200 Lockwood Dr Silver Spring 20901  |  |  |  |  |  |  |  |                 |     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | COUNTY   |  | STATE           |     |  |          |
| BURIAL  |  | 2/26/79  |  | PARKWOOD CEMETERY  |  | BALTIMORE  |  | MONTGOMERY   |  | MARYLAND        |     |  |          |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                 |     |  |          |
| NAME ADDRESS  |  |  |  |  |  |  |  |  |  |                 |     |  |          |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |  |  |  |  |  |  |                 |     |  |          |

FEB 27 1979

FRANCIS J. COLLINS  
500 CHRYSLER BLDG., NEW YORK 20, N.Y.

PARSONS CENTER

97/62/3

147532

5904571AD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 79-04636 |  |
|--|--|--|--|--|--|--|--|--|--|-------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |                   |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                   |  |
| 13a. STATE   |  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. IN "CITY LIMITS?" YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |                   |  |
| 17. INFORMANT  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |                   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)             |                   |  |
| 21d. INJURY OCCURRED   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  | 21g. CITY OR TOWN  |                   |  |
| 21h. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  | 21i. LOCATION  |  | 21j. CITY OR TOWN  |  | 21k. COUNTY  |                   |  |
| 21l. STATE   |  |  |  |  | 21m. CITY OR TOWN  |  | 21n. COUNTY  |  | 21o. STATE   |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1-79 to 2-12-79, that (I) (we) last saw the deceased alive on 2-12-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS   |  | 22f. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22g. REGISTRAR'S SIGNATURE   |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |                   |  |
| 23e. CITY OR TOWN  |  |  |  |  | 23f. COUNTY  |  | 23g. STATE   |  | 23h. DATE REC'D. BY REGISTRAR  |                   |  |
| 24. FUNERAL DIRECTOR'S NAME  |  |  |  |  | 24a. ADDRESS   |  | 24b. CITY OR TOWN  |  | 24c. COUNTY  |                   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04637

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |   |  |   |  |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Demitrious P. Diamantidis</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-13-79</b>                   |   |  | 2b. HOUR<br><b>10<sup>30</sup> A.M.</b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 26 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>82</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Turkey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Florist</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Mont.</b>   |   | 13c. CITY OR TOWN<br><b>Kensington</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>10920 Conn Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Pascal Diamantides</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK Panagiotias</b> |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>082 28 8708</b>                          |   | 17. INFORMANT<br><b>Same as above</b> ADDRESS                                  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Month</b>            |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>February 29</b> , 19 <b>79</b> , to <b>February 13</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>February 13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death.)           |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Benjamin Hines</b>  |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/13/79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Benjamin Hines, M.D.</b>   |  |   | 22e. ADDRESS<br><b>3720 Pennmut. Ave. Ken. Md. 2070</b>                 |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2/16/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>S.S. Mont. Md.</b>                             |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi F.H.</b>  |  |   | ADDRESS<br><b>11800 N.H.Ave. Silver Spring, Md.</b>                     |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1979</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-04638  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 16 79   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathryn M. Dick  |  |   |  | 2b. HOUR 10 <sup>30</sup> A M  |  |   |  |
| 3. SEX female   |  | 4. RACE white   |  | 5. DATE OF BIRTH MONTH DAY YEAR May 1, 1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 56 years YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY? U S A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Takoma Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. STATE Md   |  |   |  | 13b. CITY OR TOWN Pro Georges Riverdale  |  | 13c. STREET ADDRESS 5800 Ravenswood Road  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leo B Drager  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Womer  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  | 16b. SOCIAL SECURITY NO. 185 14 8109  |  | 17. INFORMANT ADDRESS John L Dick Riverdale, Md.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 8 squamous cell cancer of the lung<br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-13, 19 79, to 2-16, 19 79, that (I) (we) last saw the deceased alive on 2-16, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE Kai-Yiu Yeung, M.D.  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 2-16-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yiu Yeung, M.D.   |  | 22e. ADDRESS 6525 Belcrest Rd #460 Hyattsville, MD 20782  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE Feb 20, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md  |  |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 23 1979  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

88210-21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.<br>79-04639  |
|--|--|--|--|---|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Viola Mae Diggs   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 7, 1979                                     |  | 2b. HOUR<br>M  |  |   |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 15, 1900  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7919 Spiceberry Circle #C                  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Md.  |  |  |  | 13c. COUNTY<br>Montg.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>7919 Spiceberry Circle #C   |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Nathan Duvall   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eliza Braxton   |  |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>220-38-3765   |  | 17. INFORMANT ADDRESS<br>William Duvall (Cousin)  |  | 8615 Emory Grove Rd<br>Gaithersburg, Md.   |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause from line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Verticalricular Fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary Atherosclerosis</u>                                |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>1/2 Hour</u><br><u>20 Yrs.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Diabetes Mellitus, Mild; Degenerative Arthritis.</u>   |  |  |  |   |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 19 1955</u> to <u>February 19 79</u> , that (I) (we) last saw the deceased alive on <u>Jan. 15, 19 79</u> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |
| 22b. SIGNATURE<br><u>Clive E. Jackson, M.D.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>2-9-79</u>  |  |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CLIVE E. JACKSON</u>   |  | 22e. ADDRESS<br><u>202 Martins Ln., Rockville, Md. 20850</u>   |  |   |  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-12-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Emory Grove Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Gaithersburg, Montg. Md.               |  |  |  |   |
| 24. FUNERAL DIRECTOR NAME<br>George R. Snowden   |  | 24b. ADDRESS<br>246 N. Washington St.<br>Rockville, Md. 20850  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Mary McReady</u>  |  |   |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04640

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |  |  |
|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>mattie Drucilla W. Dillard   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 3, 1979 |   |   | 2b. HOUR<br>3:28 p.m.                                    |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 7-1985  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>93                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mississippi   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Toloma Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>NOT A SUCH FACILITY, GIVE STREET ADDRESS<br>7905 Cole Ave. Toloma Park |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                   |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Montgomery   |   | 13c. CITY OR TOWN<br>Toloma Park                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William O. Keasey   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dolly Usery   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-54-5061   |   | 17. INFORMANT ADDRESS<br>Joseph Macmillan (Daughter) 13e |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable aortic MI<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Previous CVA with R-sided hemiparesis & aphasia |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min.  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/30/79 to 2/3/79, that (I) (we) last saw the deceased alive on 2/1/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>David Cromwell MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>2/4/79                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David Cromwell  |  |   |  | 22e. ADDRESS<br>531 University Blvd E. Spring, Md 20903   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb 6-1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>George Washington   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>P. Geo. Md    |  |
| 24. FUNERAL DIRECTOR<br>Arthur Walters   |  |   |  | DATE REC'D. BY REGISTRAR<br>2546222-1276-7-1979   |   | 25. REGISTRAR'S SIGNATURE<br>Ruthy McCreedy              |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-04641   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | I. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Giuseppe <sup>MIDDLE</sup> DiMatteo <sup>LAST</sup> DiMatteo                     |  | 2a. DATE OF DEATH MONTH DAY YEAR 2/8/79   |  |
| 3. SEX Male   |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 03 02 1895  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.   |  |
| 10. CITY OR TOWN OF DEATH Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 13a. STATE VA   |  | 13b. COUNTY -  |  | 13c. CITY OR TOWN Wash. DC  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Matteo DiMatteo   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anziata Marinello   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. B & O Railroad                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  | 16b. SOCIAL SECURITY NO. A-579-01-2938   |  | 17. INFORMANT 1214-160mac School Rd. Elizabeth Marrocco McLean, Va.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart Failure   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 4299 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Organic heart disease   |  |  |  | H-5 years   |  |
| (c)   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13/79 to 2/8/79, that (I) (we) lost saw the deceased alive on 1/13/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE Andrew E. Rudnai M.D. DEGREE   |  |  |  | 22c. DATE SIGNED 2/8/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW E. RUDNAI  |  |  |  | 22e. ADDRESS 4600 Lingstr. Alex. Va.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (RECEIPT) Burial  |  | 23b. DATE 2-12-79  |  | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.   |  |
| 24. FUNERAL DIRECTOR NAME Nailey's F.H. Inc.  |  | ADDRESS Mt. Rainier, Md.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.  |  |
| 25a. DATE REC'D. BY REGISTRAR FEB 13 1979   |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

11310-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04642

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Katharine P. Disharoon</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2/21/79</b>   |  | 2b. HOUR <b>11:05</b> M   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 18, 1898</b>  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>80</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                         |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Secretary</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Savings &amp;</b>                                     |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. Disharoon</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marion G. Smith</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-05-9927</b>   |  | 17. INFORMANT ADDRESS<br><b>Baldwin Dorsch, 208 Ingleside Ave.</b>                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR Accident</b><br><b>436- Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 weeks</b><br><b>9 years</b><br><b>1</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 75</b> to <b>2/21/79</b> , that (I) (we) last saw the deceased alive on <b>2/18/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (which) did not view the body after death.  |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Thos G. Ward</b>   |   |   |  | 22c. DATE SIGNED<br><b>2/22/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thos G. Ward, 6116 Belvedere, Bethesda, Md 20838</b>  |   |   |  | 22e. ADDRESS<br><b>Druid Ridge Cemetery</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/24/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                               |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Baltimore, Md.</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1979</b>   |  |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>1630 Edmondson Ave., Catonsville, Md.</b><br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>  |   |   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>   |   |   |  |   |   |

MEDICAL CERTIFICATION

BP

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

DATE: 10-1-55

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO. 79-04643  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK A. DODGE JR</b>   |  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>14</b> YEAR <b>79</b>                                |  | 2b. HOUR <b>2<sup>00</sup> P</b>   |  | 2c. MIN.   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH <b>Apr.</b> DAY <b>9</b> YEAR <b>1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | 7. IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(Ret) GSA</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Montg.</b>   |  | 13c. CITY OR TOWN <b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>7704 New Market Dr.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST <b>Frederick A.</b> MIDDLE <b>Dodge,</b> LAST <b>Sr.</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Nellie</b> MIDDLE <b>Rowen</b> LAST <b>Rowen</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>577-10-4396</b>   |  | 17. INFORMANT <b>Edna K. Dodge</b>   |  |  |  | 17. ADDRESS <b>Same as 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right pleural effusion</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bronchogenic Carcinoma</b>   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>6 months</b><br><b>2 years.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> 19 <b>77</b> , to <b>February</b> 19 <b>79</b> , that (I) (yes) (no) saw the deceased alive on <b>14 Feb</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Harold I. Passes</b>  |  |   |  | DEGREE <b>MD</b>   |  |  |  | 22c. DATE SIGNED <b>14 Feb 1979</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD I. PASSES</b>   |  |   |  | 22e. ADDRESS <b>4425 Montgomery Ave Bethesda Md 20814</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Feb. 17, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem</b>   |  | 23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY <b></b> STATE <b></b>              |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Humphrey</b> ADDRESS <b>Homes, P.A. Bethesda, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 23 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Archie McBrady</b>   |  |  |  |  |  |



34840-95

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |   |  | REG. NO. 79-04644 |
|--|--|--|--|---|---|--|--|---|--|-------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MABEL DOLLY</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 7, 1979</b> |  |  | 2b. HOUR<br><b>4:55P</b> M  |  |                   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 13, 1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>83</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN   |  |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |   |  |                   |
| 10. CITY OR TOWN OF DEATH<br><b>Potomac</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8410 Victory Lane</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |                   |
| 13a. STATE<br><b>W.Va.</b>   |  | 13b. COUNTY<br><b>Pendleton</b>  |  | 13c. CITY OR TOWN<br><b>Franklin</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Main Street</b>   |  |                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Benjamin Franklin Viquesney</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ella Thacker</b>   |   |  |  |   |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>233-50-3772-A</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Genetta McQuaine, Potomac, Md.</b>   |   |  |  |   |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b><br><b>429.2</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-10 Yrs</b> |  |  |  |   |   |  |  |   |  |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |  |   |   |  |  |   |  |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 17, 1975</b> , to <b>2/7/79</b> , 19 <b>75</b> , that (I) (we) last saw the deceased alive on <b>2/8/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |  |  |   |   |  |  |   |  |                   |
| 22b. SIGNATURE <b>Lawrence J. Thomas M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED <b>2/7/79</b>  |   |  |  |   |  |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence J. Thomas</b>   |  |  |  | 22e. ADDRESS <b>11801 Rockville Pike Rockville, Maryland</b>  |   |  |  |   |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 10, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sedar Hill Cemetery</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Franklin Pendleton W.Va.</b>                   |  |   |  |                   |
| 24. FUNERAL DIRECTOR NAME <b>David L. Smith</b> ADDRESS <b>Brown Funeral Service, Franklin, W.Va. 26807</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |                   |

BP

10-01844

10-01844

Feb. 1, 1944

DAILY

1944

LOCAL TELEPHONE  
LOCAL TELEPHONE

Lawrence J. Thomas

Dr. Ball released  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04645

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2-21-79  |  | 10 AM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female   |  | Caucasian  |  | 12/21/1891   |  | 87  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Ohio   |  | U.S.A.   |  |  |  | Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Bethesda   |  | Suburban Hospital  |  | Homemaker  |  | Home  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | Montgomery   |  | Kensington   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| Adam   |  | Sarah  |  | No   |  | 286-48-8049   |  |
| 17. INFORMANT  |  | ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Cerebrovascular accident  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days                 |  |
| Mary Ellen Eder, same as #13   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |   |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 73, to 2/21 79, that (I) (we) last saw the deceased alive on 2/17 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |
| Lewis Cahill   |  | MD   |  | 2/21/79  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |
| LEWIS CAHILL MD  |  | 5411 W. CEDAR LN. BETHESDA, MD   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |  | 2/26/79  |  | St. Joseph's Cemetery  |  | Columbus, Ohio  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE RECD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Robert A. Pumphrey Funeral Homes, P.A.   |  | MAR 01 1979  |  | History McCreedy   |  |   |  |
| 7557 Wisconsin Ave., Bethesda, MD  |  |  |  |  |  |   |  |

MEDICAL CERTIFICATION

79-04645

|        |             |                              |      |        |        |         |                                |    |                     |           |      |
|--------|-------------|------------------------------|------|--------|--------|---------|--------------------------------|----|---------------------|-----------|------|
| No     | 286-48-8049 | Mary Ellen Eder, same as #13 | Adam | Maurer | Sarah  | Shields | Maryland Montgomery Kensington | XX | 4104 Mitscher Court | Homemaker | Home |
| Female | Caucasian   | 12/21/1891                   | 87   | Ohio   | U.S.A. | XX      |                                |    |                     |           |      |



10-010-01

57

USA

Non-Viol

Room

Room

Room

Room

Room no 13

Room no 13

Room no 13

Room no 13

Room no 13

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.

1979 January 10, Silver Spring, Md.



Dr. Ball Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04647

|  |        |   |          |  |                   |  |         |                      |         |                    |                                 |                    |
|--|--------|---|----------|--|-------------------|--|---------|----------------------|---------|--------------------|---------------------------------|--------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        | FIRST MARY  | MIDDLE L | LAST DUVALL  | 2a. DATE OF DEATH |  | MONTH 2 | DAY 15               | YEAR 79 | 2b. HOUR           | 11:54                           | AM                 |
| 3. SEX   | Female |   | 4. RACE  | White  |                   | 5. DATE OF BIRTH   | MONTH 8 |                      | DAY 8   | YEAR 1917          | 6. AGE (IN YEARS LAST BIRTHDAY) |                    |
|  |        |   |          |  |                   | 61   |         | YRS.                 |         | 7. IF UNDER 1 YEAR |                                 | 8. IF UNDER 24 HRS |
|  |        |   |          |  |                   |  |         |                      |         | MONTHS             |                                 | DAYS               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?  |          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |         |                      |         |                    |                                 |                    |
| Georgia  |        | U.S.A.  |          |  |                   | MONTGOMERY MD.   |         |                      |         |                    |                                 |                    |
| 10. CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                   | 12b. KIND OF BUSINESS OR INDUSTRY                              |         |                      |         |                    |                                 |                    |
| BETHEDA  |        | SUBURBAN HOSPITAL   |          | Night Admiss. Super.   |                   | Georgetown Univ. Hosp  |         |                      |         |                    |                                 |                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |        |   |          | 13d. INSIDE CITY LIMITS?   |                   | 13e. STREET ADDRESS  |         |                      |         |                    |                                 |                    |
| 13a. STATE   |        | 13b. COUNTY   |          | 13c. CITY OR TOWN  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         | 3825 Davis Pl., N.W. |         |                    |                                 |                    |
| D.C.   |        |   |          | Washington   |                   |  |         |                      |         |                    |                                 |                    |
| 14. FATHER'S NAME  |        | 15. MOTHER'S MAIDEN NAME  |          |  |                   |  |         |                      |         |                    |                                 |                    |
| FIRST MIDDLE LAST  |        | FIRST MIDDLE LAST   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| Atwell C. Williamson   |        | Margaret Hill   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |        | 16b. SOCIAL SECURITY NO.  |          | 17. INFORMANT  |                   | ADDRESS  |         |                      |         |                    |                                 |                    |
| No   |        | 578-07-5882   |          | Son  |                   | Xenia, Ohio  |         |                      |         |                    |                                 |                    |
|  |        |   |          | Frederick W Duvall.  |                   | 2655 Cold Spring Dr.   |         |                      |         |                    |                                 |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE INFEROPOSTERIOR MI<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARDIOGENIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>23 HRS<br>23 HRS |        |   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>NONE KNOWN   |        |   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| 19a. DATE OF OPERATION   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |          | 20a. AUTOPSY?  |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |         |                      |         |                    |                                 |                    |
| 2/14/79  |        | COMPLETE HEART BLOCK<br>CARDIOGENIC SHOCK   |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         |                      |         |                    |                                 |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |          | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |  |         |                      |         |                    |                                 |                    |
|  |        | P.M. 19   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |          | 21f. LOCATION<br>STREET  |                   | CITY OR TOWN   |         | COUNTY               |         | STATE              |                                 |                    |
|  |        |   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14/79 to 2/15/79, that (I) (we) lost<br>saw the deceased alive on 2/15/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death.                                  |        |   |          |  |                   |  |         |                      |         |                    |                                 |                    |
| 22b. SIGNATURE   |        | DEGREE  |          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |                   | 22c. DATE SIGNED   |         |                      |         |                    |                                 |                    |
| ROGER STEVENSON JR   |        | MD  |          |  |                   | 2/15/79  |         |                      |         |                    |                                 |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |        | 22e. ADDRESS  |          |  |                   |  |         |                      |         |                    |                                 |                    |
| ROGER STEVENSON JR   |        | 11125 ROCKVILLE PIKE ROCKVILLE, MD  |          |  |                   |  |         |                      |         |                    |                                 |                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |        | 23b. DATE   |          | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |         |                      |         |                    |                                 |                    |
| Cremation  |        | 2/16/1979   |          | Cedar Hill Crematory   |                   | Suitland, Maryland.  |         |                      |         |                    |                                 |                    |
| 24. FUNERAL DIRECTOR<br>NAME   |        | 25a. DATE REC'D. BY REGISTRAR   |          | 25b. REGISTRAR'S SIGNATURE   |                   |  |         |                      |         |                    |                                 |                    |
| JOSEPH GAWLER & SONS INC.  |        | FEB 21 1979   |          | Rickey McCready  |                   |  |         |                      |         |                    |                                 |                    |
| 8128 WISC. AVE. N. W. WASH. D. C. 20012  |        |   |          |  |                   |  |         |                      |         |                    |                                 |                    |

BP

74310-07

MARY JACOB DUBALL

61

Sept. 8, 1917

Miss

Female

8

U.S.A.

Georgia

Wright, Miss. Super. (Columbus, Ohio)

1917 Davis, W.A.

Washington

U.S.

MAIL

Columbus, Ohio

Wright, Miss

Washington

U.S.

Georgia

1917 Davis, W.A. (Columbus, Ohio)

Wright, Miss

Washington

U.S.

Georgia

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

79-04648

FOR  
1 - STATE  
REGISTRAR

EICHNER, Lester

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LESTER EICHNER</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/5 Jan. 5 1979</b> OUR <b>6 22 P.M.</b>              |   |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JAN 3, 1891</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>88</b>          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>G.P.O.</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT.</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>MONTGOMERY</b>   | 13c. CITY OR TOWN<br><b>BETHESDA</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>10523 MONTROSE AVENUE</b>                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM F. EICHNER</b>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>KATHERINE SCHAEFFER</b>                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES   |  | 16b. SOCIAL SECURITY NO.<br><b>215-46-4877</b>  |  | 17. INFORMANT ADDRESS<br><b>JEWELL S. EICHNER SAME AS 13 WIFE</b>                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hemiparesis - Renal shut down,</b><br><b>4413</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ruptured abdominal aortic aneurysm</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>25 Dec 78</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured abd. aortic aneurysm</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>25 Dec</b> , 19 <b>78</b> , to <b>5 Jan</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Joseph F. Schanno MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH SCHANNO</b>  |  | 22e. ADDRESS<br><b>8218 Shocoiner Ave Beth Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>1/8/79</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |  | 23d. LOCATION CITY OR TOWN<br><b>SUITLAND</b>                                     | PRI GEO MD.  |
| 24. FUNERAL DIRECTOR NAME<br><b>FRANCIS J. COLLINS</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1979</b>   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>   |  |   |  |   |  |

87-010-28

FISHER

215-16-4877

JAN 5, 1991

WHITE

MALE

M.S.A.

MARYLAND

MONTGOMERY

U.S. COURT

G.P.O.

HOLY CROSS HOSPITAL

STREET SPRING

1000 MONTGOMERY AVENUE

XX

MONTGOMERY COUNTY, MARYLAND

SCHWARTZ

KATHESTER

FISHER

T.

WILLIAM

215-16-4877 JAMES S. FISHER SAME AS 13 WIFE

*[Faint handwritten notes and signatures, including "James S. Fisher" and "Wife"]*

JOSEPH SCHWARTZ

WILLIAM - 1000 MONTGOMERY AVENUE

CECIL WILL

1/1/79

BURIAL

FRANK J. COLLIER

500 LEXINGTON BLVD. ST. STEVE SPRING, MD. 20707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                     |   |   |  |   |  |   | REG. NO. 79-04649  |  |
|---|--|--|---------------------|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |                     |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR A M                     |  |   |  |   |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Elmer I. Ellsworth  |  |  |                     |   | February 3 1979 4:00 A M  |  |   |  |   |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Caucasian  |                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 14 1921  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.                                     |   | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                         |   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Kensington  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>11116 Lund Place |                     |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Developer     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.     |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br>Md. Montgomery   |  |  |                     |   | 13c. CITY OR TOWN<br>Kensington                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>11116 Lund Place             |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Elmer E. Ellsworth  |  |  |                     |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edith Fort          |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  |  |                     |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>1942-1945 |  | 17. INFORMANT ADDRESS<br>Sylvia Ellsworth/See Item # 13   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic hypernephroma</u><br>1890<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |                     |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                     |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 20 1978, to 2/3 79, that (I) (we) last saw the deceased alive on Feb 2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |                     |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Lewis H. Dennis</i>  |  |  |                     |   |   | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/3/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lewis H. Dennis, M.D.  |  |  |                     |   |   | 22e. ADDRESS<br>831 University Blvd. Silver Spring Md.                         |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2-5-79 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery           |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rockville Mont. Md.   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey Funeral Homes P.A.  |  |  |                     |   |   | 25a. DATE RECD. BY REGISTRAR<br>FEB 7 1979                                     |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Mary MacCreedy</i> |  |  |
| 25c. ADDRESS<br>7557 Wisconsin Ave. Bethesda, Maryland  |  |  |                     |   |   |  |   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04650  
VICTOR M. EISENBEISS

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH                                |  | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE  |  |
| Victor M. Eisenbeiss   |  | MALE   |  | WHITE  |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                  |  | 7. IF UNDER 1 YEAR                               |  |
| JAN. 29, 1900  |  | 79 YRS.  |  | MONTHS DAYS HOURS MIN.                           |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH             |  | 10. CITY OR TOWN OF DEATH                        |  |
| WASHINGTON, D.C.   |  | Montgomery Co. MD.                               |  | Bethesda   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  | 12a. USUAL OCCUPATION                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| Suburban Hospital  |  | MECHANIC   |  | N.O.L. (RET.)                                    |  |
| 13a. STATE   |  | 13b. COUNTY                                      |  | 13c. CITY OR TOWN                                |  |
| D.C.   |  | NASHINGTON                                       |  | 13d. INSIDE CITY LIMITS?                         |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                         |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?      |  |
| VICTOR HUGO EISENBEISS   |  | NELLIE MELLIS                                    |  | YES NO   |  |
| 16a. YES   |  | 16b. SOCIAL SECURITY NO.                         |  | 17. INFORMANT                                    |  |
| W.W.-II  |  | 578-01-0959                                      |  | BEATRICE EISENBEISS                              |  |
| 18. CAUSE OF DEATH   |  | 19. STREET ADDRESS                               |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) EXTENSIVE METASTATIC CANCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) UNKNOWN       |  | 19 WHITTIER ST. N.W.                             |  | 1990   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| NONE EXCEPT SIP RT UPPER LOBE SURGERY IN 1955  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?                                    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  | 21a. ACCIDENT WAS UNDERLYING                     |  | 21b. TIME OF INJURY                              |  |
| YES NO   |  | OR CONTRIBUTING CAUSE OF DEATH                   |  | HOUR A.M. MONTH DAY YEAR                         |  |
| YES NO   |  | (IF EITHER, NOTIFY MEDICAL EXAMINER)             |  | P.M. 19  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION                                    |  |
| WHILE AT WORK NOT WHILE AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 22b. SIGNATURE                                   |  | 22c. DATE SIGNED                                 |  |
| 1-30, 1979, to 2-13, 1979, that (I) (we) lost  |  | Samuel Stodberg                                  |  | 2-13-79  |  |
| saw the deceased alive on 2-13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)            |  | 22e. ADDRESS                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY               |  |
| Burial   |  | Feb. 20, 1979                                    |  | Rock Creek Cemetery                              |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                    |  | 25b. REGISTRAR'S SIGNATURE                       |  |
| Arthur Walter  |  | FEB 21 1979                                      |  | L. H. McCready                                   |  |



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Admission" and "Date" are faintly visible.]*

*[Faint text at the bottom of the page, possibly a signature or footer.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |   |   |   | REG. NO. 79-04651   |  |
|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Benjamin David Embree  |   |   |   | 2a. DATE KNOWN OF DEATH MATED<br>MONTH DAY YEAR HOUR<br>Feb. 1 1979 3:45 AM         |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY  | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.                        | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR HOUR<br>02 01 79 3:45 AM                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                     |   |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |   |   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |   | ADDRESS   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Low Kamia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |   |   |   |   |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |   | M.D.  |   | DATE SIGNED   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION BY OR TOWN  |   | COUNTY STATE  |  |
| Burial   | Feb 2-1979   | Gate of Heaven  |   | Silver Spring   |   | Montgomery Co. Md   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |   |   |  |
| Arthur Walters   |  | FEB 6 1979  |   | Anthony McCready  |   |   |  |

10-04621

Boys in David's Dress

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 79-04652                            |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR                                     |  |
|   |  | FIRST MIDDLE LAST Robert A. Ernst   |  |  |  |  |  | 2. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |
|   |  |   |  |  |  |  |  | 2. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |
| 3. SEX M  |  | 4. RACE W   |  | 5. DATE OF BIRTH MONTH DAY YEAR 4-6-36   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.  |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD                     |  |
|   |  |   |  |  |  |  |  |  |  | 2d. HOUR                                     |  |
|   |  |   |  |  |  |  |  |  |  | 2d. HOUR                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| South Carolina  |  | U.S.A.  |  |  |  | Montgomery   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Bethesda  |  | Suburban Hospital   |  |  |  | Unemployed   |  | None   |  |  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| Md  |  | Montgomery  |  | Rockville  |  |  |  | 636 Goldsborough Drive   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Malcolm L. Ernst  |  |   |  | Elizabeth Anne Oliphant  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| No  |  |   |  | 253-82-6661  |  | Malcolm L. Ernst (Same as 13e)   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 9550 Gun Shot Wound of Head.  |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Self-Inflicted -   |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
|   |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 1:15 P.M. 2-21 1979  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
|   |  |   |  |  |  | Shot self in head with hand gun -  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Garage -   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 636 Goldsborough Rd. Rockville Mont. Md.      |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE John G. Ball   |  |   |  | TITLE (SPECIFY) Deputy   |  |  |  | DATE SIGNED Feb 21/1979  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball  |  |   |  | ADDRESS Old Georgetown Rd., Bethesda, Md.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION   |  |   |  | 23b. DATE 2-26-79  |  | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.                           |  |  |  |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes   |  |   |  | 25a. DATE REC'D. BY REGISTRAR MAR 01 1979  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| P.A., Bethesda, Maryland  |  |   |  |  |  |  |  |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                           |  |   |  |   |  |   |  | REC. NO. 79-04653   |  |
|--|--|---------------------------|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                           |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) OSCAR NOEL ETHIER  |  |                           |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 1 26 79                |  | 2b. HOUR OF DEATH<br>10 A M   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR May 26, 1915   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 63 YRS.  |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Jan. 26 1979  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Hampshire   |  |                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CO. MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  |                           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Administrative Officer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>C I A  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                           |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery |  | 13c. CITY OR TOWN<br>Rockville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>311 Mt. Vernon Place   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Ethier  |  |                           |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Odiele Moquin                                  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W. W. #2   |  | 17. INFORMANT<br>ADDRESS<br>Eleanor J. Ethier-Wareham, Mass. 297 Marion Road,                   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) <u>Cardio Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |                           |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  |                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .  |  |                           |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>John G. Ball   |  |                           |  |   |  | TITLE (SPECIFY)<br>M.D. DePuty  |  | MEDICAL EXAMINER<br>DATE SIGNED Jan 26, 1979  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) JOHN G. BALL  |  |                           |  |   |  | ADDRESS<br>7936 OLD GEORGETOWN RD. MD   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Cremation   |  |                           |  | 23b. DATE<br>1/30/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory-Suitland, P. G. Co., Md.             |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.W. Chambers Co.  |  |                           |  |   |  | ADDRESS<br>Silver Spring, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1979   |  |   |  |
|  |  |                           |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. ...   |  |   |  |

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John C. Bane

Mr. C. Bane



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04654

|  |  |                      |  |  |  |  |  |  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|--|--|-------------------------|--|--|--|--|--|-------------------------|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <u>Feb 13 1979</u> |  |  |  |                         |  |  |  |  |  | 2b. HOUR <u>3:20</u> AM |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Isabel J. Evans</u>  |  |                      |  |  |  |  |  |  |  | 21. DATE OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <u>Feb 13 1979</u>                  |  |  |  |                         |  |  |  |  |  | 2b. HOUR <u>3:20</u> AM |  |
| 3. SEX <u>Female</u>   |  | 4. RACE <u>Cauc.</u> |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>7 25 99</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>79 YRS.</u>               |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  | 22. DATE PRONOUNCED DEAD <u>Feb 13 1979</u>                                      |  | 2b. HOUR <u>3:20</u> AM |  |  |  |  |  |                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.                       |  |                         |  |  |  |  |  |                         |  |
| 10. CITY OR TOWN OF DEATH <u>Sil. Spgs</u>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Cottage Hill Nursing Home</u> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>                                    |  |                         |  |  |  |  |  |                         |  |
| 13a. STATE <u>DC</u>   |  |                      |  | 13b. COUNTY <u>N/A</u>   |  | 13c. CITY OR TOWN <u>Washington</u>                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <u>5245 42nd St. N.W.</u>   |  |  |  |                         |  |  |  |  |  |                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>John Scott</u>  |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth King</u>   |  |  |  |  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>   |  |                      |  | 16b. SOCIAL SECURITY NO. <u>577-38-7094</u>  |  |  |  | 17. INFORMANT ADDRESS <u>Victor R. Evans, Same as 13</u>   |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Acute Myocardial D.I.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Arterio sclerotic Cardiovas. D.I.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u><br><u>3 days</u><br><u>4 yrs</u> |  |                      |  |  |  |  |  |  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Fracture Rte Hip</u>   |  |                      |  |  |  |  |  |  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| 19a. DATE OF OPERATION <u>1-24-79</u>  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fracture of Rt. Hip</u>   |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                         |  |  |  |  |  |                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>8:11 1979</u>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fall at Home</u>  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>42nd St. N.W. Wash. DC</u>   |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .   |  |                      |  |  |  |  |  |  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| ACTUAL SIGNATURE <u>John S. Rogers</u>   |  |                      |  | TITLE (SPECIFY) <u>1919 Seminary Road</u>  |  |  |  | DATE SIGNED <u>Feb. 13/1979</u>  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers</u>  |  |                      |  | ADDRESS <u>Silver Spring, Maryland 20910</u>   |  |  |  |  |  |   |  |  |  |                         |  |  |  |  |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>   |  |                      |  | 23b. DATE <u>2-14-79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crem.</u> |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Alexandria, Virginia</u>                                     |  |  |  |                         |  |  |  |  |  |                         |  |
| 24. FUNERAL DIRECTOR NAME <u>ROBERT A. BIMPHEY FUNERAL HOMES, P. A., Bethesda, Maryland</u>  |  |                      |  | 25a. DATE REC'D. BY REGISTRAR <u>FEB 21 1979</u>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Lillian McCready</u>   |  |   |  |  |  |                         |  |  |  |  |  |                         |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |   |  |                             |   |                        |   |  |  |  | REG. NO. 79-04655   |                     |
|---|-------------------------|--|---|--|-----------------------------|---|------------------------|---|--|--|--|---|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RAFFORD L. FAULKNER</b>  |                         |  |   |  |                             |   |                        |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> <b>Feb. 22, 1979</b> | 2b. HOUR <b>6P.</b> |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 24, 1909</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>70</b> | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>Feb. 22, 1979</b>   | 7d. HOUR <b>6:15P.</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> |  |  |  |   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maine</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dir. Div. Raw Materials ADC</b>                                 |                        |   |  |  |  |   |                     |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8624 Beech Tree Road</b> |   |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY   |                        |   |  |  |  |   |                     |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  |   |  |                             |   |                        |   |  |  |  |   |                     |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Bethesda</b>   |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                        | 13e. STREET ADDRESS<br><b>8624 Beech Tree Road</b>        |  |  |  |   |                     |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles H. Faulkner</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Helen -- Taylor</b>   |                             |   |                        |   |  |  |  |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-44-0054</b>   |                             | 17. INFORMANT ADDRESS<br><b>Concetta D. Faulkner, Same as #13.</b>  |                        |   |  |  |  |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun Shot - Wound Head -</b><br>9550<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Self Inflicted -</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |                         |  |   |  |                             |   |                        |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |  |                             |   |                        |   |  |  |  |   |                     |
| 19a. DATE OF OPERATION  |                         |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                             |   |                        |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>5:35 P.M. 2 22 1979</b>  |                         |  |   | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR<br><b>5:35 P.M. 2 22 1979</b>   |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Shot self in head with 22 cal. Rem-um gun -</b> |                        |   |  |  |  |   |                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                         |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home -</b>   |                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>8624 Beech-tree Rd. Bethesda Montgomery Md.</b>                                |                        |   |  |  |  |   |                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |  |                             |   |                        |   |  |  |  |   |                     |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |                         |  |   | TITLE (SPECIFY) M.D. <b>Deputy</b>   |                             |   |                        | DATE SIGNED <b>Feb. 22, 1979</b>                          |  |  |  |   |                     |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>   |                         |  |   | ADDRESS <b>7936 Old Georgetown Rd., Bethesda, Md.</b>  |                             |   |                        |   |  |  |  |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |                         |  |   | 23b. DATE<br><b>2/23/79</b>  |                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |                        |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland, Maryland</b>             |  |   |                     |
| 24. FUNERAL DIRECTOR NAME<br><b>Jos. Gawler's Sons, Washington, D.C. 20016</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1979</b>  |                             |   |                        | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>          |  |  |  |   |                     |

79-01622

REPORT

DATE: 10/1/79

X

REMARKS:

1. The following information was obtained from the file:

1. The following information was obtained from the file:

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |        |  |                                  |   |          | REG. NO. 79-04656                            |  |
|---|--|--|--|--|--------|--|----------------------------------|---|----------|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  | MIDDLE | LAST   | 2a. DATE OF DEATH MONTH DAY YEAR |   | 2b. HOUR |  |  |
|   |  | Thomas RAYMOND Flynn   |  |  |        |  | 2-25-79                          |   | 5:45 PM  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |        | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                  | IF UNDER 1 YEAR MONTHS DAYS   |          | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male  |  | Caucasian  |  | 5 3 1898   |        | 80   |                                  |   |          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                  |   |          |  |  |
| Chicago, Ill  |  | USA  |  |  |        | Montgomery MD.   |                                  |   |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                  | 12b. KIND OF BUSINESS OR INDUSTRY   |          |  |  |
| Wheaton, MD   |  | Manor Care Wheaton   |  |  |        | Cashier - Auditor  |                                  |   |          |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. STREET ADDRESS  |        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |   |          |  |  |
| MD  |  | Montgomery   |  | SILVER SPRING  |        | 3401 KAYSON STREET   |                                  |   |          |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |        | 16b. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT   |          | ADDRESS                                      |  |
| JOSEPH  |  | Theresa  |  | NO   |        | 436-03-9987  |                                  | JOSEPHINE LOWE FLYNN  |          | SAME AS 13 WIFE                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |        |  |                                  |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Stroke</u>   |  |  |  |  |        |  |                                  |   |          | 2 weeks                                      |  |
| 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>   |  |  |  |  |        |  |                                  |   |          | 5 years                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |        |  |                                  |   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |        |  |                                  |   |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |        |  |                                  |   |          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |        |  |                                  |   |          |  |  |
|   |  | P.M. 19  |  |  |        |  |                                  |   |          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |        |  |                                  |   |          |  |  |
|   |  |  |  |  |        |  |                                  |   |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>September 1978</u> to <u>Feb 25</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Feb 17</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |        |  |                                  |   |          |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |        | 22c. DATE SIGNED   |                                  |   |          |  |  |
| <u>[Signature]</u>  |  | M.D.   |  |  |        | Feb 25, 1979   |                                  |   |          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |        |  |                                  |   |          |  |  |
| BLAINE H. EIG   |  | 98012 Long in Greenfield, Md 20902   |  |  |        |  |                                  |   |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |        | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                                  |   |          |  |  |
| BURIAL  |  | 2/28/79  |  | GATE OF HEAVEN   |        | SILVER SPRING MONT MD.   |                                  |   |          |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |        | 25b. REGISTRAR'S SIGNATURE   |                                  |   |          |  |  |
| FRANCIS J. COLLINS  |  |  |  | FEB 27 1979  |        | <u>[Signature]</u>   |                                  |   |          |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |  |        |  |                                  |   |          |  |  |

MEDICAL CERTIFICATION

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BP

3402

90-01888

DAVIDSON

2301 KAYSON STREET  
SILVER SPRING, MARYLAND

SILVER SPRING  
MARYLAND

JOSEPH  
DAVIDSON

346-03-9807 JOSEPHINE LONE FLYNN  
SAME AS 13 WIFE

NO

SON WITH ALICE V. SILVER SPRING MD. 20807  
FRANCIS J. COLLINS

BURIAL 2/28/73 DATE OF DEATH SILVER SPRING MONT. MD.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>STATE<br>REGISTRAR  |  |                  |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |  |  |  |  | 79-04657<br>REG. NO. |  |
|--|--|------------------|--|---|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul B. Fonda   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>2/19 1979   |  |   |  |   |  |  |  |  |  | 2b. HOUR<br>P.M.     |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>Jun. 17, 1889   |  | 6. AGE (IN YEARS)<br>89 YRS.                             |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>2/19 1979   |  | 2d. HOUR<br>8:00 P.M.   |  |  |  |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                       |  |   |  |  |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1910 Corwin Drive |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bank Examiner  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.                                     |  |   |  |  |  |  |  |                      |  |
| 13a. STATE<br>Maryland   |  |                  |  |   |  |  |  |   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1910 Corwin Drive |  |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>(unknown)  |  |                  |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>(unknown)                         |  |   |  |   |  |  |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>220-44-0824   |  |  |  | 17. INFORMANT<br>Robert A. Gingell-Atty. Mill Rd. S.S.  |  |  |  | ADDRESS<br>11151 Viers  |  |   |  |  |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic cardiovascular disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Years   |  |  |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None  |  |                  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION<br>None   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>None   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| ACTUAL SIGNATURE<br>   |  |                  |  | TITLE (SPECIFY)<br>Deputy   |  |  |  | MEDICAL EXAMINER<br>1919 Seminary Road<br>Silver Spring, Montgomery, Md.  |  |  |  | DATE SIGNED<br>2/20/79  |  |   |  |  |  |  |  |                      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers, M.D.   |  |                  |  | ADDRESS<br>1919 Seminary Road<br>Silver Spring, Montgomery, Md.   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>Feb. 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenwood Cemetery |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>St. Albans Vermont                   |  |   |  |   |  |  |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.  |  |                  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| 25a. DATE REC'D BY REGISTRAR<br>FEB 26 1979  |  |                  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                      |  |
| 25b. REGISTRAR'S SIGNATURE<br>   |  |                  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                      |  |



72340-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-04658  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR MIN   |  |   |  |
| Sarah A. French   |  |  |  | 2-6-79 1:43 PM   |  |   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS  |  |
| Female  |  | white  |  | Nov. 1 1899  |  | 79 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Illinois  |  | USA  |  |  |  | Montgomery MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Silver Spring, Md.  |  | Holy Cross Hosp.   |  | Housewife  |  | own home  |  |
| 13a. STATE  |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS   |  |
| Maryland  |  |  |  | Montgomery   |  | 209 Hartwell Road,  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |
| Ingemund Lund   |  |  |  | (unknown)  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT (son) ADDRESS  |  |
| no  |  |  |  | none   |  | 6303 Prospect Terr., Alex. Va.  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) Cordo respiratory arrest  |  |  |  |  |  |   |  |
| 436- DUE TO, OR AS A CONSEQUENCE OF (b) Stroke syndrome   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| Diabetes Mellitus   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1972, to February 6, 1979, that (I) (we) lost saw the deceased alive on February 5, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE DEGREE   |  |  |  | 22c. DATE SIGNED   |  |   |  |
| Hugo G. Graziani M.D.   |  |  |  | 2-6-79   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |
| Hugo G. Graziani M.D.   |  |  |  | 800 PERSHING Dr. 303A Silver Spring, Md., 20910.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial  |  | 2-10-79  |  | Cedar Hill Cemetery  |  | Suitland Pr. Georges Md.  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Warner E. Pumphrey, INC.  |  |  |  | FEB 15 1979  |  |   |  |
| 8434 Ga. Ave., S.S. Md.   |  |  |  |  |  |   |  |

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1- FOR  
 STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

79-04659

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edith B. FULLER</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/9/79</b>   |  | 2b. HOUR<br><b>6:15 PM</b>   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 19 59</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hungary</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>3601 S. Leisure World Blvd.</b>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luis Jurkovich</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Buda</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.<br><b>449-24-0804</b>   |  | 17. INFORMANT <b>Husband</b> ADDRESS<br><b>Frank L. Fuller. Same as item 13.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardio-respiratory failure</b><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>hepatic insufficiency</b><br>(c) <b>cirrhosis of liver</b> |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>2 yrs</b><br><b>2 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 73</b> to <b>9 Feb 19 79</b> , that (I) (we) last saw the deceased alive on <b>9 Feb 19 79</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Joseph M. Wymann</b>  |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/10/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph M. Wymann</b>   |   | 22e. ADDRESS<br><b>7801 Rockville Ave Bethesda, Maryland</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>2/13/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland.</b>  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH GAWLER'S SONS INC.</b>   |   | ADDRESS<br><b>8129 WISG AVE, N. W. WASH, D. C. 20016</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1979</b>                              |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |  |  | REG. NO. 79-04660  |  |  |  |
|---|--|----------------------|--|---|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |                      |  |   |  | 2a. DATE KNOWN OF DEATH  |  |  |  |  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHARLOTTE D GANNETT</b>   |  |                      |  |   |  | MONTH DAY YEAR <b>2 23 1979</b>                                    |  |  |  |  |  | 4A M   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH (MONTH DAY YEAR) <b>5-17-20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58 YRS.</b>                     |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>FEB 23 1979</b>  |  | 2d. HOUR <b>4A</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                       |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp. DOA</b> |  |  |  | 12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>                                |  |
| 13a. STATE <b>MARYLAND</b>  |  |                      |  |   |  | 13b. COUNTY <b>MONT.</b>   |  | 13c. CITY OR TOWN <b>CHEVY CHASE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>7310 MEADOW LANE</b>                                      |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>JOHN ALBERT PEELER</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>WILLANA WALKER</b> |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN) <b>YES</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>215-44-4051</b>   |  | 17. INFORMANT <b>MICHAEL R. GANNETT</b>                            |  |  |  | ADDRESS <b>SAME AS ITEMS #13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                      |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 1 DEATH WAS CAUSED BY:   |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <b>4392 Coronary Insufficiency Acute</b>  |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>(b) Cardio Vascular Disease</b>  |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| (c)   |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| <b>Diabetes Mellitus</b>  |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. DePoty</b>  |  |  |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>Feb 23 1979</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN G. BALL</b>   |  |                      |  | ADDRESS <b>7936 OLD GEORGETOWN RD</b>   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>  |  |                      |  | 23b. DATE <b>2/24/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREM.</b>         |  |  |  | 23d. LOCATION (CITY OR TOWN) <b>SUITLAND - P.G. MD.</b>                                      |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS CO. MD.</b>  |  |                      |  | ADDRESS <b>SILVER SPRING</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1979</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McBrody</b>                                |  |

00040-01



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04661

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Max Gans   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-18-79   |  | 2b. HOUR<br>8:05 AM   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 1, 1882  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Russia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96<br>YRS. MONTHS DAYS HOURS MIN.                            |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Merchant  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Paper   |  |   |  |
| 13a. STATE<br>D. C.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Washington   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3528 Northampton St., N. W.   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leib Genzeloff  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>153-24-1396A  |  | 17. INFORMANT<br>Rose Sturm   |  |
|   |  |  |  | ADDRESS<br>Same as No. 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>1369<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infection</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Severe coronary artery disease</u>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-12-79</u> to <u>1-18-79</u> , that (I) (we) last saw the deceased alive on <u>1-17-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |
| 22b. SIGNATURE<br><u>HADI BAHAR</u>   |  | DEGREE   |  | 22c. DATE SIGNED<br>1-18-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HADI BAHAR   |  | 22e. ADDRESS<br>8218 Wisconsin Ave. Bethesda   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  | 23b. DATE<br>1/21/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King David Memorial Garden                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Falls Church, Virginia  |  | 23e. DATE REC'D. BY REGISTRAR<br>JAN 23 1979   |  | 23f. REGISTRAR'S SIGNATURE<br>L. J. McCreedy  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Donald M. Stein Hebrew Memorial F.H.<br>232 Carroll Street, N. W. Washington, D. C.   |  |  |  |   |  |

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RECEIVED  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 79-04662                            |  |          |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|----------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 2a. DATE OF DEATH  |   |  |  |  | MONTH DAY YEAR                               |  | 2b. HOUR |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | Ernest C. Gartner  |   |  |  |  | 2 19 79 3 <sup>30</sup> P. M.                |  |          |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |          |  |  |
| Male  |  | Caucasian  |  | Sept. 25 189  |  | 89 YRS  |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |          |  |  |
| Pa.   |  | U.S.A.   |  |   |  | Montgomery MD.  |  |  |  |  |  |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |          |  |  |
| Rockville   |  | Rockville Nursing Home   |  |   |  | Funeral Director  |  | Funeral  |  |  |  |          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |  |  |          |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |          |  |  |
| Md.   |  | U.S.A.   |  | Gaithersburg  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 320 E. Diamond Avenue  |  |  |  |          |  |  |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |  |  |          |  |  |
| George Michael Gartner  |  |  |  |   | Emma Jane Haywood  |   |  |  |  |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |  |  |          |  |  |
| No  |  | -  |  | 217-36-6675   |  | Rosabell G. Sandison 316 E. Diamond Ave., Gaithersburg, Md.         |  |  |  |  |  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |          |  |  |
|   |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1975, 19, to Feb 19, 1979, that (I) (we) lost<br>saw the deceased alive on 2-1-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |          |  |  |
| 22b. SIGNATURE  |  |  |  |   | DEGREE   |   |  |  |  | 22c. DATE SIGNED                             |  |          |  |  |
| L. I. Lenz  |  |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |  | 20760  |  |          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS   |   |  |  |  |  |  |          |  |  |
| L. I. Lenz  |  |  |  |   | Gaithersburg, Maryland 20760   |   |  |  |  |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |  |  |          |  |  |
| Burial  |  | 2/24/79  |  | Forest Oak Cemetery   |  | Gaithersburg Montgomery Md.   |  |  |  |  |  |          |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |          |  |  |
| Rosabell Sandison Gartner-Sandison F. H.  |  |  |  | 316 E. Diamond Ave., Gaithersburg, Md.  |  |   |  | FEB 28 1979  |  |  |  |          |  |  |

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19-04662



|                     |                    |                            |                  |
|---------------------|--------------------|----------------------------|------------------|
| Mr. J. Edgar Hoover | Director           | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |
| Mr. J. Lee Rankin   | Assistant Director | U.S. Department of Justice | Washington, D.C. |

Enclosed for Mr. J. Lee Rankin are two copies of a letterhead memorandum dated and captioned as above. One copy of the same is being furnished to Mr. J. Edgar Hoover for his information.

Very truly yours,  
J. Lee Rankin

Enclosed for Mr. J. Lee Rankin are two copies of a letterhead memorandum dated and captioned as above. One copy of the same is being furnished to Mr. J. Edgar Hoover for his information.

Very truly yours,  
J. Lee Rankin

APPROVED BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 79-04663 |  |
|---|--|---|--|---|--|--|--|--|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELISABETH H. GAZIN</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2. 4. 79</b>   |  | 2b. HOUR<br><b>7:29 AM</b>   |  |          |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 12 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY Co MD.</b>   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Carriage Hill--Bethesda</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Librarian (Ret)</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Smithsonian</b>  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   |  | 13c. CITY OR TOWN<br><b>Montgomery</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>6420 Broad St.</b>   |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Hobbs</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Houghton</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  |          |  |
| 16b. SOCIAL SECURITY NO.<br><b>535-44-8772</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Charles L. Gazin, Husband, Same as item 13.</b>  |  |   |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Angiographic lateral sclerosis</u><br><b>3352</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hypertensive + arteriosclerotic vascular disease</u>   |  |   |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION<br><b>2/9</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> , 19 <u>59</u> , to <u>2/5</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><u>H. Luther Hall, MD.</u>  |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/5/1979</b>  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. LUTHER HALL MD.</b>   |  |   |  | 22e. ADDRESS<br><b>6000 WISC. AVE. CHEVY CHASE, MD.</b>   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/9/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Maryland.</b>   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH CAWLER'S SONS INC.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony A. Brady</u>  |  |  |  |          |  |
| 8130 WISC. AVE., N. W. WASH., D. C. 20010   |  |   |  |   |  |  |  |  |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 79-04664  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>JACOB   |  | FIRST MIDDLE LAST<br>GILL  |  | 2a. DATE OF DEATH MONTH 21 YEAR 1929 HOUR 7:40 P.M.                                  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 23, 1907                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4620 North Park Avenue                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |
| 13a. STATE<br>Florida   |  | 13b. COUNTY<br>Palm Beach  |  | 13c. CITY OR TOWN<br>Palm Beach  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Hyman  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rose Unknown   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self Employed       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>057-07-3427  |  | 17. INFORMANT ADDRESS<br>Ida Gill, 3590 S. Ocean Blvd., Palm Beach, Fla.             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma Urinary Bladder   |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>one year                             |  |
| 1889  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 1928, 19, to Feb 20, 1929, that (I) (we) last saw the deceased alive on 18 Feb 1929, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br>Horace Bernton  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/20/29  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Horace Bernton, M. D.  |  | 22e. ADDRESS<br>4743 Bradley Blvd. Chevy Chase, Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2-23-29   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Beth David Cemetery                            |  |
| 24. FUNERAL DIRECTOR NAME<br>Danzansky-Goldberg Mem. Chap.  |  | 24b. ADDRESS<br>Rockville, Md.   |  | 24c. LOCATION CITY OR TOWN COUNTY STATE<br>Elmont, N. Y.                             |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1929  |  | 25b. REGISTRAR'S SIGNATURE<br>H. H. Brady  |  |  |  |



70-04664

100

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR AKA Walter Edward Gill Sr. CERTIFICATE OF DEATH

REG. NO.

79-04665

|   |                      |   |  |  |  |
|---|----------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Walter GILL  |                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 13 1979   |  | 2b. HOUR<br>10:07A M   |  |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 5 1919   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |                      | 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Army  |                      | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Florida   |                      |   |  |  |  |
| 13b. COUNTY<br>Orange   |                      | 13c. CITY OR TOWN<br>Orlando  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br>4444 Rio Grande Ave. Apt. 426T   |                      | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Gill   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Shutek   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1937-68  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Lotte M. Gill See item 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Adenocarcinoma of the lung complicated by bronchopneumonia<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |                      |   |  |  |  |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                      | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                      | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      | 22a. I certify that (I (this hospital) attended the deceased from Jan. 8, 1979, to Feb. 13, 1979, that (we) lost<br>saw the deceased alive on Feb. 13, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Michael D. Mahoney, M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED<br>Feb. 13 1979  |                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael D. Mahoney, M.D.   |  | 22e. ADDRESS<br>National Naval Medical Center Bethesda, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                      | 23b. DATE<br>2/17/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Orlando Orange Florida  |                      | 24. FUNERAL DIRECTOR<br>NAME<br>Metropolitan Funeral Service Alexandria Va.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1979   |  |
| 25b. REGISTRAR'S SIGNATURE<br>P. J. McCready  |                      |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

79-04666

|  |  |  |   |   |  |  |  |  |  |  |  |   |  |  |
|--|--|--|---|---|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>William V. Gillespie</u>  |  |  | 2a. DATE OF DEATH<br>Month <u>2</u> Day <u>21</u> Year <u>79</u> 1 P. M.                  |   |  | 2b. HOUR   |  |  |  |  |  |   |  |  |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>Caucasian</u>  |   | 5. DATE OF BIRTH<br><u>9 - -01, 1903</u>  |  | 6. AGE (In years last birthday)<br><u>75</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN                    |  |  |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>North Carolina</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Montgomery</u> Md.  |  |  |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Takoma Park</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Washington Adv. Retired Electrical Services</u> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Montgomery</u>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET AND NUMBER<br><u>7309 Jackson Ave</u>  |  |  |  |  |  |   |  |  |
| 14. FATHER'S NAME<br>First <u>William V.</u> Middle <u>Gillespie</u> Last <u>Gillespie</u>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <u>Minnie</u> Middle <u>Jerrill</u> Last <u>Jerrill</u> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes, give year or dates of service)<br><u>No</u> |  |  | 16b. SOCIAL SECURITY NO.<br><u>579-48-4593</u> |  |  | 17. INFORMANT<br><u>Patricia Jones</u> 49-26- <u>Atlanta, Ga.</u> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Nephrosclerosis</u><br>4039<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Uremia</u>   |  |  |   |   |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>26 Jan</u> , 19 <u>79</u> , to <u>22 Feb</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>22 Feb</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |   |   |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Mona P. Fogarty M.D.</u>  |  |  |   | 22c. DATE SIGNED<br><u>22 Feb 79</u>  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br><u>Mona P. Fogarty</u>               |  |  |  |   |  |  |
| 22e. ADDRESS<br><u>254 CARRON ST., N.W.</u>  |  |  |   | 22f. ADDRESS<br><u>Wash., D.C. 20012</u>  |  |  |  | 22g. ADDRESS<br><u>254 CARRON ST., N.W.</u>                          |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>R-26-1979</u>  |  | 23b. DATE<br><u>2-26-1979</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Takoma Park</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Silver Spring, Md.</u>                           |  | 23e. REGISTRAR'S SIGNATURE<br><u>John J. Brady</u>                   |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>J.A. WALKERS, Takoma F.H. Inc.</u>  |  | 24a. ADDRESS<br><u>254 CARRON ST., N.W.</u>  |   | 24b. ADDRESS<br><u>Wash., D.C. 20012</u>  |  | 24c. DATE<br><u>FEB 2 1979</u>   |  | 24d. REGISTRAR'S SIGNATURE<br><u>John J. Brady</u>                   |  |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 79-04667                                     |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| Shirley   |  | XXX   |  | Goldgraben  |  |   |  | 2 26 79  |  | 5 55 PM                                      |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |
| FEMALE  |  | WHITE   |  | FEB. 22, 1902   |  | XXX 77 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| HUNGARY   |  | USA   |  |   |  | Montgomery MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Silver Spring   |  | Holy Cross Hospital   |  |   |  |   |  | ACCOUNTANT   |  | A.L.EOLIS CO.                                |  |
| 13a. USUAL RESIDENCE (STATE OR FOREIGN COUNTRY)   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |  |  |  |  |
| Maryland  |  | Bronx   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 2161 BARNES AVE.  |  |  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |  |  |
| ISAAC   |  | ALTMAN  |  | AMALIA FISH   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |   |  |  |  |  |  |
| NO  |  | 066-05-5371A  |  | WEST END FUNERAL CHAPEL<br>200 W. 91ST ST. NEW YORK, NY 10024   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) OBSTRUCTIVE JAUNDICE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) PANCREATIC CANCER |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
|   |  |   |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/19/79, to 2/26/79, that (1) (we) last saw the deceased alive on 2/25/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE  |  |   |  |   |  | 22c. DATE SIGNED   |  |  |  |
| file man  |  | MD  |  |   |  |   |  | 2/26/79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |  |  |  |  |
| JOEL GOOZH  |  | 4701 RANDOLPH RD #105 Rockville, MD 20852   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | 23e. STATE   |  |  |  |
| REMOVAL/BURIAL  |  | FEB. 28, 1979   |  | CEDAR PARK  |  | ORDELL  |  | NEW JERSEY   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE                                       |  |  |  |
| NAME SOL LEVINSON & BROS., INC.   |  | FEB 28 1979   |  |   |  |   |  | History McCreedy   |  |  |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215   |  |   |  |   |  |   |  |  |  |  |  |

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(VRA 15, 4) 7/78TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |                          | REG. NO. 79-04668                            |  |
|--|--|---|--|---|--|--|--|---|--------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>DONALD WARD GRAFFIUS</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>FEB 16, 1979</b>   |  |   | 2b. HOUR <b>6:31 P M</b> |  |  |
| 3 SEX <b>MALE</b>  |  | 4 RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 17, 1895</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |                          | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>MONTGOMERY</b> MD.                         |  |   |                          |  |  |
| 10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOKBINDER</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>GPO</b>  |                          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>PRI. GEO</b>   |  | 13c. CITY OR TOWN <b>HYATTSVILLE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2304 WOODBERRY STREET</b>  |                          |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY W. GRAFFIUS</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET HAMM</b>  |  |  |  |   |                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO. <b>215-44-8585</b>   |  | 17 INFORMANT <b>MARIE A. GRAFFIUS</b>   |  | ADDRESS <b>SAME AS 13 WIFE</b>   |  |   |                          |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY DISTRESS</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC ASPIRATION PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GENERALIZED ARTERIOSCLEROSIS</b> |  |   |  |   |  |  |  |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>DEMENTIA, CORONARY ARTERY DISEASE, STRESS ULCER</b>   |  |   |  |   |  |  |  |   |                          |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |  |  |  |   |                          |  |  |
| 22b. SIGNATURE <b>M. SNOW MD</b>   |  |   |  |   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                          | 22c. DATE SIGNED                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. SNOW</b>   |  |   |  |   |  | 22e. ADDRESS <b>9013 FLOWER AVENUE, SILVER SPRING, MD. 20901</b>                             |  |   |                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>2/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>                         |  |   |                          |  |  |
| 24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>  |                          |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |  |   |  |  |  |   |                          |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04669

|  |  |   |  |   |   |   |  |   |   |  |  |
|--|--|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDMUND L. GREEN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>12</b> YEAR <b>79</b>                         |   |   | 2b. HOUR <b>9:55</b> AM   |  |   |   |  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>20</b> YEAR <b>94</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ST. LOUIS, MO.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                     |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BIO-CHEMIST (RESEARCH)</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FED GOVT.</b>   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  |   | 13b. COUNTY <b>MONT.</b>   |   | 13c. CITY OR TOWN<br><b>TAKOMA PARK</b>                             |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>107 TULIP AVENUE</b>                  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>EDMUND</b> MIDDLE <b>ARNER</b> LAST <b>GREEN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>HARRIET</b> MIDDLE <b>VON DER AU</b> LAST <b>AU</b> |   |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |   | 16b. SOCIAL SECURITY NO<br><b>220-42-2500</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>CAROLYN O. GREEN, 107 TULIP AVE</b>  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myocardial Infarct</b>               |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Hours</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic angina x 20 yrs Hypertension</b>  |  |   |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79                            |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-12-79</b> to <b>1-12-79</b> , that (I) (we) last saw the deceased alive on <b>1-12-79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>John L Ford MD</b>  |  |   | DEGREE   |   |   | 22c. DATE SIGNED<br><b>1/12/79</b>  |  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN L FORD</b>  |  |   | 22e. ADDRESS<br><b>344 University Blvd W<br/>Silver Spring, Md</b>                       |   |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  |   | 23b. DATE<br><b>JAN 17 1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Crematory</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Takoma Funeral Home &amp; Mortuary</b>  |  |   | ADDRESS<br><b>254 Carroll Dr NW DC</b>   |   |   | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 18 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |  |

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Dr. Ball released to Dr. Schanno  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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BP

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

79-04670

1- FOR  
 STATE  
 REGISTRAR

|  |  |  |  |   |   |  |   |   |  |
|--|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Pauline Joan Greene   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/ 1/ 79                        |   |   | 2b. HOUR<br>9:02p M  |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 3, 1926   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montg.  |   | 13c. CITY OR TOWN<br>Bethesda                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul Fuller  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Farrel          |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-22-4119 |   | 17. INFORMANT<br>ADDRESS<br>Charles E. Greene, Same as 13 |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive Hemorrhage from</u><br><u>4440</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>abdominal aortic aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br>1/25/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>aortic aneurysm  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 23</u> , 19 <u>79</u> , to <u>Feb 2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Feb 1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><u>Joseph F. Schanno</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |  |   | 22c. DATE SIGNED<br><u>Feb 3/79</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph F. Schanno   |  |  |  | 22e. ADDRESS<br><u>228 Phoenician Ave Beth. Md</u>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>2-8-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia                   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1979  |   |  |   |   |  |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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25-8-31 1901-1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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| 1. FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 79-04671   |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |  |  |
| DOSWELL   |  |  |  | GULLATT  |  |  |  | FEBRUARY 15, 1979  |  |  |  |
| 3 SEX<br>MALE   |  |  |  | 4. RACE<br>CAUCASIAN   |  |  |  | 5. DATE OF BIRTH<br>AUGUST 16, 1898  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>LOUISIANA  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NATIONAL NAVAL MEDICAL CENTER           |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY                                   |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |
| 13a. STATE<br>DC  |  |  |  | 13b. COUNTY<br>WASHINGTON  |  |  |  | 13c. STREET ADDRESS<br>4545 CONNECTICUT AVE  |  |  |  |
| 14. FATHER'S NAME<br>LEE  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>DORA TRUSSELL  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  |  |  | 16b. SOCIAL SECURITY NO.<br>457-42-6490  |  |  |  | 17. INFORMANT<br>NELLY GULLATT   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEMMORHAGIC PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from 18 JANUARY 19 79 to 15 FEBRUARY 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.)                             |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>J.S. BOHAN MMD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>2/16/79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS<br>NNMC BETHESDA, MD. 20014   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  |  | 23b. DATE<br>Feb 20, 1979  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NATIONAL                             |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ARLINGTON VIRGINIA  |  |  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HINES RINALDI FUNERAL HOME SILVER SPRING, MD   |  |  |  |  |  |  |  |
| 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04672

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |
|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lena W. Guyer</b>                       |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>#</b> YEAR <b>79</b>   |   | 2b. HOUR<br><b>6:25pm</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>15</b> YEAR <b>1880</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS<br>IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring Md</b>                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Althea Woodland Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |
| 13a. STATE<br><b>D.C.</b>   | 13b. COUNTY<br><b>Wash.</b>  | 13c. CITY OR TOWN<br><b>Wash.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4824 Piney Branch Rd. NW</b>   |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>Winey</b> LAST <b>Schull</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Schull</b> LAST <b>Schull</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>578-62-0109</b>  |   | 17. INFORMANT<br><b>Grace Niece</b> ADDRESS<br><b>1838 Conn. Ave. Wash.</b>  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>429.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 days</b> |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>Feb 4 1979</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Heart Failure</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 4 1979</b> to <b>Feb 4 1979</b> , that (I) (we) saw the deceased alive on <b>Feb 4 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Bernard A. Fitzgerald</b>   |  | DEGREE<br><b>Attending Physician</b>   | 22c. DATE SIGNED<br><b>2-4-79</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>  |  | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD E, SILVER SPRING, MD</b>                      |  |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2/7/1979</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN <b>Ft. Meyer, Virginia</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH GAWLER'S SONS INC.</b><br>ADDRESS<br><b>1130 WISG. AVE., N. W. WASH., D. C. 20005</b> |                              | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 8 1979</b>                     |   |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 79-04673  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 4 79  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence Fred Haake   |  |  |  | 2b. HOUR 3:00 <sup>A</sup> M   |  |   |  |
| 3. SEX Male  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 3 22 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY railroad  |  |
| 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 1211 Autre Court  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Haake  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dykeman  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  |  |  | 16b. SOCIAL SECURITY NO. WW I  |  | 17. INFORMANT Kline ADDRESS Audrey C. Kline Same as item #13 a-e  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>496-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Chronic Obstructive Lung Disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 73, to 2/4 19 79, that (I) (we) last saw the deceased alive on 2/3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |  |  |   |  |
| 22b. SIGNATURE M.R. Cardo  |  |  |  | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED 2/4/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL R. CASCARDO   |  |  |  | 22e. ADDRESS 12400 BOBINK CT POTOMAC Md - 20854  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation  |  | 23b. DATE 2/5/79   |  | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia  |  |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. Rockville, Maryland 20852   |  |  |  | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 7 1979   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | REG. NO. 79-04674   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Gwendolyn J. Haffner</u>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <u>03</u> DAY <u>10</u> YEAR <u>79</u>   |  | 2b. HOUR<br><u>9:55</u> AM  |  |   |  |
| 3. SEX<br><u>F</u>  |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>26</u> YEAR <u>14</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>64</u> YRS                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Pennsylvania</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                         |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Holy Cross Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Reg. Nurse</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Nursing</u>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <u>MD</u> COUNTY <u>Montgomery</u> CITY OR TOWN <u>Silver Spring</u>  |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS<br><u>16 Skinnyside Road</u>                                      |  |   |  |
| 14. FATHER'S NAME<br>FIRST <u>Channey</u> MIDDLE <u>N.</u> LAST <u>Johnson</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Jenny</u> MIDDLE <u></u> LAST <u>Moser</u>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>no</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>457-52-7091</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>William F. Haffner-husband-(same as 13c)</u>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory and cardiac arrest</u><br>5119<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>massive pleural effusion and</u><br>(c) <u>pneumonitis</u> |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br><u>5830 CAMERON STREET</u>   |  | CITY OR TOWN<br><u>SILVER SPRING, MD.</u>   |  | COUNTY<br><u>MD.</u>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-7-79</u> to <u>2-10-79</u> , that (I) (we) last saw the deceased alive on <u>2-10-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                            |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Jason Geiber, M.D.</u>   |  |   |  | 22c. DATE SIGNED<br><u>2.10.79</u>  |  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JASON GEIBER, M.D.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  |   |  | 23b. DATE<br><u>2-13-79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>                        |  | 23d. LOCATION<br>CITY OR TOWN<br><u>Rockville</u> COUNTY<br><u>Montgomery</u> STATE<br><u>Md.</u>                                     |  |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey, Inc.</u><br>8434 Ga. Ave., S.S. Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 16 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Clark E. Akron</u>                                   |  |   |  |

70-01674



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REC. NO. 79-04675 |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH D. HAGAN</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2 17 1979</b> |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>7:59 AM</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH (MONTH DAY YEAR) <b>Sept 6 1900</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>78 YRS.</b>  |  |  |  |  |  |  |  |  |  | 7c. DATE PRONOUNCED DEAD <b>2 17 1979</b>   |  |  |  |  |  |  |  |  |  | 2d. HOUR <b>7:59 AM</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>S. T. Lloyd</b>   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>                      |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.-Steelworker</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Mont</b> 13c. CITY OR TOWN <b>Readington</b>   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS <b>4120 Dacotah Ave.</b>   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>G.</b> LAST <b>Hagan</b>   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b>Ann</b> LAST <b>Massie</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>WW II 305-05-4730</b>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS <b>Maria S. Hagan, Same as #13.</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>887-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Fracture Rt. Hip</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>15 days</b>  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>Feb 18/79</b>  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture Rt. Hip</b>   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 2-2 19 79</b>  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>   |  |  |  |  |  |  |  |  |  | 21f. LOCATION CITY OR TOWN <b>Dacotah</b> COUNTY <b>Readington</b> STATE <b>Mont Md</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY) <b>M.D. Dep.</b>  |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>Feb 17/79</b>   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>  |  |  |  |  |  |  |  |  |  | ADDRESS <b>Silver Spring, Montg. Co., Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE <b>2/21/79</b>  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Washington, D.C. 20016</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN <b>Silver Spring, Md.</b>  |  |  |  |  |  |  |  |  |  | 23e. STATE <b>Md.</b>  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1979</b>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Patricia Braddy</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |

25010-01

UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | REG. NO. 79-04676  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CLARA ELMA HAIR</b>   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEB. 04 1979</b>                                     |  |  | 2b. HOUR<br><b>1235A</b>   |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 12 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                               |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>                               |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  |  |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>BETHESDA</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>5300 RIDGEFIELD RD</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS HAMMAN</b>  |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SUSSANAH MENCH</b>                       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   |  | 17 INFORMANT <b>BETHESDA MD</b> ADDRESS <b>DAUGHTER DOROTHY BRIGULIO 5300 RIDGEFIELD RD</b> |  |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Distress</b><br><b>496-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic obstructive Lung Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____       |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>01 FEB 79</b> , 19 <b>79</b> , to <b>1235 04 FEB 19 79</b> , that (1) (we) lost saw the deceased alive on <b>04 FEB 79</b> , 19 <b>79</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James A. Halley L.H.M. D.O.</b> ATTENDING PHYSICIAN  |  |  |  |  |  |   |  | 22c. DATE SIGNED<br><b>4 Feb 79</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES A. HALLEY</b>  |  |
| 22e. ADDRESS<br><b>NNMC, Bethesda Md.</b>   |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>REMOVAL-BURIAL</b>  |  |  |  | 23b. DATE<br><b>2-7-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Middletown Cem.</b>                                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middletown, Pa.</b> |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH GAUWER SONS WASHINGTON, D.C.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>                          |  |  |  |

MEDICAL CERTIFICATION

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BP

10-01616

001125

15352

FEB. 14 1975

MALE

CLARA ELIA

64

FEB 25 1975

CANADIAN

FEMALE

MONTGOMERY

USA

PENNSYLVANIA

1975

PHONETIC

LAVAL HOSPITAL

BETHESDA

1000 RIDGEFIELD RD

POSTGRADUATE MEDICAL

MD

1975

2122 ANNA RD

HAWAII

LOT 12 HAWAII

DAUGHTER

BETHESDA MD

1000 RIDGEFIELD RD

UNKNOWN

NO

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1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04677

|  |  |                  |               |   |  |              |  |   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
|--|--|------------------|---------------|---|--|--------------|--|---|-------------------------------|--|-------------------------------|--|---|---|------------|--|--|--|---|--|--------------|--|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>John |   |  | MIDDLE<br>B. |  |   | LAST<br>Hale                  |  |                               | 2a. DATE KNOWN OF DEATH<br>ESTIMATED   |   |   | MONTH<br>2 |  |  | DAY<br>11                                    |   |  | YEAR<br>1979 |  |  | 2b. HOUR<br>M |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-13-58  |  |              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>19 YRS. |   | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 11 1979 |   |            | 2d. HOUR<br>5:00AM                               |  |  | M |  |              |  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               |  |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                       |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |                  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |              |  |   |                               |  |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                |   |   |            | 12b. KIND OF BUSINESS OR INDUSTRY                |  |  |   |  |              |  |  |               |  |
| 13a. STATE<br>Maryland   |  |                  |               | 13b. COUNTY<br>Montgomery   |  |              |  | 13c. CITY OR TOWN<br>Lanham   |                               |  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |            | 13e. STREET ADDRESS<br>10,007 Greenbelt Rd. #201 |  |  |   |  |              |  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bobby L. Hale, Sr.   |  |                  |               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice A. Reggi   |  |              |  |   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |                  |               | 16b. SOCIAL SECURITY NO.<br>213-90-5164   |  |              |  | 17. INFORMANT<br>Bobby L. Hale, Sr. Same as # 13  |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Scoliosis</u><br>7373 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |               |   |  |              |  |   |                               |  |                               |  |   |   |            |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |              |  |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |               |   |  |              |  |   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 19a. DATE OF OPERATION   |  |                  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |              |  |   |                               |  |                               |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |  |  |  |   |  |              |  |  |               |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |               |   |  |              |  |   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| ACTUAL SIGNATURE   |  |                  |               | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |              |  |   |                               |  |                               |  |   | DATE SIGNED<br>2/12/79  |            |  |  |  |   |  |              |  |  |               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |               | ADDRESS<br>111 Penn St. Balto., MD.   |  |              |  |   |                               |  |                               |  |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |               | 23b. DATE<br>2-14-79  |  |              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>George Wash. Cemetery   |                               |  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Adelphi, Md.                           |   |   |            |  |  |  |   |  |              |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert G. Beall Funeral Home   |  |                  |               | ADDRESS<br>9013 Annapolis Rd. Lanham, Md. 20801   |  |              |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1979  |                               |  |                               | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy                                       |   |   |            |  |  |  |   |  |              |  |  |               |  |

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5-10-60  
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RECEIVED

U.S. DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |                    | REG. NO. 79-04678  |  |
|--|--|--|--|---|--|--|--|---|--------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Thomas P. Halloran  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 14 1979   |  |   | 2b. HOUR<br>11 A M |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 25 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |                    | 7. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery   |  |   | 9. MD.             |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nursing Home |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Letter Carrier |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Post Of  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville   |  |  |  |   |  |  |  |   |                    |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Halloran  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Coyne   |  |   |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>WWI Navy 063-32-9019  |  | 17. INFORMANT ADDRESS<br>Jean E. Seaton (same as 13e)  |  |   |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebrovascular Thrombosis</i><br>4340<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>Cerebral Arteriosclerosis</i><br>(c) <i>Generalized Arteriosclerosis</i> |  |  |  |   |  |  |  |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 DAY<br>2 YRS<br>10 YRS.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |                    |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                    |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18/79, 19 to 2/14/79, 19, that (I) (we) last saw the deceased alive on 2/18/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |                    |  |  |
| 22b. SIGNATURE<br><i>Henry Scruggs</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/14/79   |                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry Scruggs, M.D.   |  |  |  |   |  | 22e. ADDRESS<br>5413 W. Cedar Lane Bethesda Md.  |  |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>2-19-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Syracuse Onondaga N.Y.                       |                    |  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY<br>HOMES, P.A. ROCKVILLE MARYLAND  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barry Kennedy</i>                                      |                    |  |  |



87880-99

History

Language

Life

Rockville

Rockville Valley Nursing Home

Rockville

Rockville

001-22-0010

Henry Schuyler, Jr.

8413

Leedy Lane Bethesda, Md.

Serial

U.S. National Archives

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |   |
|---|--|--|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR <b>Jayne T. Hardesty</b>   |  | REG. NO. <b>79-04679</b>   |  |   |  |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Jayne T. Hardesty</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 22, 1979</b>   |   |  |  |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 31, 1880</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b>  |  | 7b. HOUR<br><b>3 PM</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                                       |  | MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>TakomaPk., Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>P.G.</b>   |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1911 Erie St. #104</b>   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Oliver Birekhead</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Elizabeth Paddy</b>  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>265-40-7724A</b>  |  | 17. INFORMANT ADDRESS<br><b>326 S. C. Ave S.E. Wash.D.C. 20003</b><br><b>R. Burnett Thompson -nephew</b>  |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Colon w. th metastasis</b><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>over 1 yr.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23/79</b> , to <b>2/24/79</b> , that (I) (we) lost (saw) the deceased alive on <b>2/21/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>David Cromwell M.D.</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>2/23/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David K. Cromwell M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>831 University Blvd. East Sil. Sp., Md.</b>   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-26-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Lee Funeral Home</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>History McBrady</b>             |  |   |

24. FUNERAL DIRECTOR

NAME

300-4th St. N.E. Wash.D.C.

20002

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

19-04679

James T. H. Heston

13

Aug. 31, 1960

white

Merle

USA

Marvin

x

front cover

Horsehead

Thompson, Ed.

1911 White St. 104

Huntville

Ed. P.O.

Henry Elizabeth Taylor

Blair

Oliver

306 S. C. Ave S.E. Wash.D.C.

R. Burnett Thompson - memo

65-10-77

None

to

University of Maryland

David H. Green et al M.D.

London P. H. Cemetery Baltimore, Md.

65-70

Burial

See Funeral Home 300-14th St. N.W. Wash.D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH** 99-04680

|  |  |  |        |  |                                     |   |          |   |      |
|--|--|--|--------|--|-------------------------------------|---|----------|---|------|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle | Last   | 20. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR |   |      |
| Louise Rhea Heddings   |  |  |        |  | February 17, 1979                   |   | 9:30a.M. |   |      |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |                                     | 6. AGE (In years last birthday)   |          | 7. YRS.   |      |
| female   |  | white  |        | March 24, 1924   |                                     | 54  |          |   |      |
| 70. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH  |          | Md.   |      |
| Virginia   |  | U S A  |        |  |                                     | Montgomery  |          |   |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                     | 12b. KIND OF BUSINESS OR INDUSTRY   |          |   |      |
| Takoma Park  |  | Washington Adventist   |        | Housewife  |                                     | Home  |          |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                                     | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                                    |      |
| Md   |  | Pro Georges  |        | Riverdale  |                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |          | 6823 Riverdale Road                                       |      |
| 14. FATHER'S NAME  |  | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME            |   | First    | Middle  | Last |
| Samuel Rhea  |  |  |        |  | Esther Cassell                      |   |          |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | (If yes give war or dates of service)  |        | 16b. SOCIAL SECURITY NO.   |                                     | 17. INFORMANT   |          | Address   |      |
| no   |  |  |        | 230 24 8306  |                                     | Merrill K Heddings  |          | Greenbelt, Md.  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Metastatic Breast Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>(Extensive)</u> |  |  |        |  |                                     |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3d</u> |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Metastatic Breast Cancer Bones, Liver, Lung.</u>   |  |  |        |  |                                     |   |          |   |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |          |   |      |
| 11/27/78   |  | Adrenalectomy.   |        | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     |   |          |   |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                                     |   |          |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                     |   |          |   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1974, to 2-17, 1979, that (I) (we) lost the deceased alive on 2-16, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |        |  |                                     |   |          |   |      |
| 22b. SIGNATURE   |  | DEGREE   |        | ATTENDING PHYS.  |                                     | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |          | 22c. DATE SIGNED  |      |
| 22d. PHYSICIAN'S NAME (Type)   |  | Robert A. Smith MD   |        | 22e. ADDRESS   |                                     | 831 University Blvd E S.S. Md.  |          |   |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION (City or Town) (County) (State)                                     |          |   |      |
| Burial   |  | Feb 22, 1979   |        | Cedar Hill Cemetery  |                                     | Suitland Pro Georges Md.  |          |   |      |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons P A Hyattsville, Md.   |  |  |        | 25a. RECEIVED BY REGISTRAR<br>DATE   |                                     | 25b. REGISTRAR'S SIGNATURE<br>FEB 23 1979   |          |   |      |

08010-95

25. 38

Robert A. Smith, Jr.

Robert A. Smith, Jr.

2/2/77

Robert A. Smith, Jr.

Robert A. Smith, Jr.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04681


1. FOR  
STATE  
REGISTRAR


REG. NO.

|  |  |  |   |  |   |   |   |   |  |  |
|--|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SARAH L. HENDERSHOT</b>                 |  |  | 2a. DATE OF DEATH MONTH <b>FEB</b> DAY <b>14</b> YEAR <b>1979</b> |  |   | 2b. HOUR <b>4 M</b>   |   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>OCT.</b> DAY <b>16</b> YEAR <b>1877</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>101</b> YRS.                                |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                     |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>PR GEO</b>                                      |  | 13c. CITY OR TOWN<br><b>TAKOMA PARK</b> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>7907 LOCKNEY AVE</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE LAST <b>GORMAN</b>            |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>NANCY</b> MIDDLE <b>WHITLATCH</b> LAST  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>234-68-5906</b>   |   | 17. INFORMANT<br><b>IDA FAY CROSS</b>  |   |   |   | ADDRESS<br><b>7907 LOCKNEY AVE T.P.</b>                 |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal aspirated pneumonia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2/12/79</b> |  |
| 5070<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b>                    |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>                    |  |

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/12/79</b> , 19____, to <b>2/14/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/13/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/14/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSOOTH LEKAGUL, MD</b>   |  |   |  | 22e. ADDRESS<br><b>7425 Arlington Rd, Bethesda, Md</b>                                     |  |   |  |

|   |  |                                   |  |  |  |   |  |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 17, 1979</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bluemont Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Grayton West Va.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>TAKOMA F.H. (J.A. Walters)</b> ADDRESS <b>254 CANTON ST., N.W., Wash., D.C. 20012</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1979</b>            |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10010-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04682

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Loretta</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>21</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>11 AM</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>NOV</b> DAY <b>30</b> YEAR <b>1891</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bel Pre Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |   | 13b. CITY OR TOWN<br><b>MONTGOMERY</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>3400 GLENEAGLES DRIVE</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>EDWARD</b> MIDDLE <b>L.</b> LAST <b>KOLB</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>OTHILDA</b> MIDDLE <b>GOEBEL</b> LAST <b>GOEBEL</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>718-14-9608</b>   |   | 17. INFORMANT <b>SON</b><br><b>MILTON L. HENRY, SR.</b>   |  | ADDRESS <b>1702 WHITE OAK DRIVE<br/>SILVER SPRING, MD.</b>                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Heart failure (congestive)</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Hypertensive-arterio-sclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>many years</b><br>(c) <b>402-</b> |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>74 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>20 May</b> , 19 <b>77</b> , to <b>21 Feb</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>20 Feb</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gustavo S. Belaval, MD</b>  |  |  |   |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>22 Feb 79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gustavo S. Belaval</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>Leisure world Medical Center<br/>Silver Spring, Md 20906</b>                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/26/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PROSPECT HILL</b>  |  | 23d. LOCATION<br>WASHINGTON, D.C. COUNTY STATE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |  |   |   |  | 25. DATE RECEIVED BY REGISTRAR <b>FEB 22 1979</b><br>REGISTRAR'S SIGNATURE                      |  |  |  |

MEDICAL CERTIFICATION

29

1

3203 BP

88-010-083

72

A.2.1

AGL:INTO

5254

TO ORDER: 1. 10/11/1989-11-217

11/2/97

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 79-04683 |  |
|---|--|---|--|---|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>EVELYN JONES HILL</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 25 79</b>  |  | 2b. HOUR<br><b>7<sup>PM</sup></b>  |  |          |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 18, 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Brooke Grove Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Gov't.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pub. Health</b>  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |  |  |          |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. CITY OR TOWN<br><b>Arundel Edgewater</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS  |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eugene D. Jones</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Lynett</b>  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577 07 2830</b>  |  | 17. INFORMANT<br><b>15012 Eastway Dr. S.S.Md.<br/>James Dalton (Son-in-law)</b>   |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION</b><br>4349<br>OR AS CONSEQUENCE OF (b) <b>PULMONARY CONGESTION</b><br>OR AS CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 HRS.</b><br><b>12 HRS.</b><br><b>YRS.</b> |  |   |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>SENILE DEMENTIA</b>  |  |   |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>4/19</b> 19 <b>75</b> , to <b>2/25</b> 19 <b>79</b> , that (we) last saw the deceased live on <b>2/25</b> 19 <b>79</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we) (did) did not view the body after death.  |  |   |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Wond R. Lewis M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/25/79</b>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. R. LEWIS M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>OLNEY, Md. 20832</b>   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>3/2/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory Brentwood P.G. &amp; Md.</b>   |  | 23d. LOCATION<br>CITY STATE  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi F.H.</b>   |  |   |  | ADDRESS<br><b>11800 N.H. Ave. S.S.Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 01 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McCreary</b>   |  |          |  |

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04684

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |                                   |  |  |
|---|--|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                               |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |  |  |
| Baby Boy Hinton   |  |  | January 24, 1979  |  |  | 8:43PM                            |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |  | 7. IF UNDER 1 YEAR                |  |  |
| Male  | Black  | January 24, 1979   | YRS. MONTHS DAYS  |  |  | HOURS MIN                         |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                         | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |                                   |  |  |
| Maryland  | U. S. A.   |  | Montgomery MD.  |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Olney   | Montgomery General Hospital  |  | N/A   |  |  |                                   |  |  |
| 13a. STATE  |  |  | 13b. CITY OR TOWN   |  |  | 13c. STREET ADDRESS               |  |  |
| Maryland  |  |  | Montgomery  |  |  | 7834 Mineral Springs Dr.          |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  |                                   |  |  |
| FIRST MIDDLE LAST   |  |  | FIRST MIDDLE LAST   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  |  | 16b. SOCIAL SECURITY NO.                                      |  |  | 17. INFORMANT ADDRESS             |  |  |
|   |  |  |   |  |  |                                   |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity - Abruptio</u><br>7657<br>DUE TO, OR AS A CONSEQUENCE OF <u>24 1/2 weeks gestation</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____                    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Ali Youssef, M. D.  |  | M.D.   |  | 1-24-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
|   |  | MGM Professional Building<br>Olney, MD 20832                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| removal   |  | 1-24-79  |  | Montgomery General   |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
|   |  |  |  | MAR 27 1979  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  |  |  | [Signature]  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-04685  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bradley Duncan Hodgkins  |  |   |  | Feb. 4 1979 10 <sup>30</sup> P M   |  |   |  |
| 3. SEX Male   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR Sept 3 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Chevy Chase   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 4413 Bradley Lane Chevy Chase |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) physician  |  | 12b. KIND OF BUSINESS OR INDUSTRY medical   |  |
| 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4413 Bradley Lane Chevy Chase           |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Grant Hodgkins  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina - Bradley  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) public health WW II   |  |   |  | 16b. SOCIAL SECURITY NO. 213-54-6357   |  |   |  |
| 17. INFORMANT ADDRESS DAVID E. MANOGIAN J.S. MD 20910 8413 Ramsey Ave   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 436- Cerebral Vascular accident<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - generalized<br>DUE TO, OR AS A CONSEQUENCE OF (c)                             |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION None   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75 to present 19, that (I) (we) lost saw the deceased alive on 2/3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE John B. Umhau MD   |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED 2/4/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau   |  |   |  | 22e. ADDRESS 8805 Conn. Ave. Chevy Chase MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE 2/5/79  |  | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia  |  |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A.   |  |   |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 7 1979   |  |   |  |
| 7557 Wisconsin Ave., Bethesda, MD   |  |   |  |  |  |   |  |



28010-05

CHITAN KARAN

1. The first part of the report is a general description of the project.

2. The second part is a description of the methodology used in the study.

3. The third part is a description of the results of the study.

4. The fourth part is a description of the conclusions of the study.

5. The fifth part is a description of the limitations of the study.

6. The sixth part is a description of the future work.

7. The seventh part is a description of the acknowledgements.

8. The eighth part is a description of the references.

9. The ninth part is a description of the appendices.

10. The tenth part is a description of the index.

11. The eleventh part is a description of the glossary.

12. The twelfth part is a description of the bibliography.

13. The thirteenth part is a description of the list of figures.

14. The fourteenth part is a description of the list of tables.

15. The fifteenth part is a description of the list of abbreviations.

16. The sixteenth part is a description of the list of symbols.

17. The seventeenth part is a description of the list of units.

18. The eighteenth part is a description of the list of equations.

19. The nineteenth part is a description of the list of formulas.

20. The twentieth part is a description of the list of diagrams.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                      |  |   |  |  |  |                       | 79-04686   |  |
|--|--|--|----------------------|--|---|--|--|--|-----------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |                      |  | REG. NO.  |  |  |  |                       |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE E. LAST Holmes   |  |  |                      |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2/19/79   |  |  |  | 2b. HOUR<br>2:55 P.M. |  |  |
| 3 SEX<br>F   |  | 4 RACE<br>N  |                      | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 09 14  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS                                       |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |                       | 7b. IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PANAMA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |                      | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                          |  |  |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |                      |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None  |                       |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13a. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring   |  |  |                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>11215 OAKLEAF DR. |  |                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Mongurate Lopez   |  |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Regina Rodrigues                                  |  |  |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>None   |                      | 17. INFORMANT<br>578-42-1770 Clifton N. Holmes   |   | 17. ADDRESS<br>Same as 13e   |  |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic insufficiency<br>5715 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cirrhosis of liver<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  |                      |  |   |  |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>HYPERSPLENTISM  |  |  |                      |  |   |  |  |  |                       |  |  |
| 19a. DATE OF OPERATION   |  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                       |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19/79 to 2/19/79, that (I) (I) last saw the deceased alive on 2/19/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |                      |  |   |  |  |  |                       |  |  |
| 22b. SIGNATURE<br>Robert Frazier MD  |  |  |                      | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   |  |  | 22c. DATE SIGNED<br>2/20/79  |                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |                      | 22e. ADDRESS<br>8630 FENTON STR SMD  |   |  |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2-24-79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland PG MD                            |                       |  |  |
| 24. FUNERAL DIRECTOR NAME<br>FRAZIER'S   |  |  |                      | ADDRESS<br>389 R.I. Ave N.W. D.C.  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 28 1979   |                       | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady  |  |

38310-05



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04687

| 1- STATE REGISTRAR   |         | FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE                 |                   | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                       |                     | REG. NO. 79-04687   |          |
|--|---------|---|-------------------|---|---------------------|---|----------|
| 1. DECEASED NAME (TYPE OR PRINT)   |         |   |                   | 2a. DATE KNOWN OF DEATH   |                     | 2b. HOUR  |          |
| Emily Buck Hook  |         |   |                   | Feb. 4 1979   |                     | 11:45 AM  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.   | 7. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD  | 2d. HOUR |
| F  | W       | Sept. 17 1928   | 80 YRS.           | MONTHS  | DAYS                | Feb. 4 1979   | 11:45 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |   |                   | 7b. CITIZEN OF WHAT COUNTRY?  |                     |   |          |
| Washington, D. C.  |         |   |                   | USA   |                     |   |          |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |         |   |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                     |   |          |
| Montgomery MD.   |         |   |                   |   |                     |   |          |
| 10. CITY OR TOWN OF DEATH  |         |   |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                      |                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |          |
| Silver Spring  |         |   |                   | Holy Cross Hospital   |                     | Housewife   |          |
| 13a. STATE   |         |   |                   | 13b. CITY OR TOWN   |                     | 13c. STREET ADDRESS   |          |
| Maryland   |         |   |                   | Montgomery  |                     | 10800 Georgia Ave Apt 202   |          |
| 14. FATHER'S NAME  |         |   |                   | 15. MOTHER'S MAIDEN NAME  |                     |   |          |
| Pierre Munzinger   |         |   |                   | Katherine Sergeant  |                     |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |                   | 16b. SOCIAL SECURITY NO.  |                     | 17. INFORMANT   |          |
| No   |         |   |                   | 218-30-2588   |                     | Paul J. Hook son  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:   |         |   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |                     |   |          |
| 4391 IMMEDIATE CAUSE (a) Acute Myocardial Dis  |         |   |                   |   |                     |   |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |   |                     |   |          |
| (b)  |         |   |                   |   |                     |   |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |   |                     |   |          |
| (c)  |         |   |                   |   |                     |   |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |                   |   |                     |   |          |
| None   |         |   |                   |   |                     |   |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |   |                     | 20. AUTOPSY?  |          |
| None   |         |   |                   |   |                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                     |   |          |
|  |         | HOUR A.M. MONTH DAY YEAR                                    |                   |   |                     |   |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   | 21f. LOCATION   |                     |   |          |
|  |         |   |                   | STREET CITY OR TOWN COUNTY STATE  |                     |   |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |   |                     |   |          |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |                   | DATE SIGNED   |                     |   |          |
| John S. Rogers, M. D.  |         | Dep   |                   | Feb. 5 1979   |                     |   |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |                   |   |                     |   |          |
| John S. Rogers, M. D.  |         | 1919 Seminary Road S. S.                                    |                   |   |                     |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY  |                     | 23d. LOCATION   |          |
| Burial   |         | Feb. 7, 1979  |                   | Rock Creek Cemetery   |                     | Washington D.C.   |          |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                               |                   | 25b. REGISTRAR'S SIGNATURE  |                     |   |          |
| Francis J. Collins   |         |   |                   | Feb 7 1979  |                     |   |          |
| 500 University Boulevard, W. Silver Spring, Md.  |         |   |                   |   |                     |   |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 79-04688  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |
| Emily Whitty HOOPER  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 11:30A M  |  |  |  |
| 3. SEX Female  |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 25 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 89   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY Home   |  |
| 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 6729 Sulky Lane  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Langley Whitty  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Elizabeth Steckel  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 429 30 8076   |  | 17. INFORMANT ADDRESS Mrs. Emily M. Weisiger See item 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 1539   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) sepsis  |  |  |  |  |  |  | 10 days  |
| DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia / Acute pancreatitis  |  |  |  |  |  |  | 10 days  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5/p colectomy Sn CARCINOMA of colon + cholecystectomy  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 1-12-79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED COLON CANCER  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1978, to Jan. 22, 1979, that (I) (we) last saw the deceased alive on Jan. 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE H. R. Sessions III MD.  |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED Jan. 23, 1979   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. SESSIONS III, MD.  |  |  |  | 22e. ADDRESS National Naval Medical Center, Bethesda, Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE Jan. 26, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY Fayetteville National   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Fayetteville Ark.  |  |
| 24. FUNERAL DIRECTOR NAME David S. Sessions  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 26 1979  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |
| Capitol Funeral Service  |  |  |  | Fairfax, Virginia  |  |  |  |

10-00000

|                        |                       |                       |                       |                       |                       |
|------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| January 12 1978 11:00A | Witty                 | 1982                  | Jan. 22               | 1978                  | 11:00A                |
| USA                    | USA                   | USA                   | USA                   | USA                   | USA                   |
| Montgomery             | Montgomery            | Montgomery            | Montgomery            | Montgomery            | Montgomery            |
| Rockville              | Rockville             | Rockville             | Rockville             | Rockville             | Rockville             |
| Langley                | Langley               | Langley               | Langley               | Langley               | Langley               |
| Witty                  | Witty                 | Witty                 | Witty                 | Witty                 | Witty                 |
| 429 30 8076            | 429 30 8076           | 429 30 8076           | 429 30 8076           | 429 30 8076           | 429 30 8076           |
| Mrs. Emily M. Weisner  | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner |
| See item 13            | See item 13           | See item 13           | See item 13           | See item 13           | See item 13           |

|                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Jan. 22 1978          | Jan. 22 1978          | Jan. 22 1978          | Jan. 22 1978          | Jan. 22 1978          | Jan. 22 1978          |
| USA                   | USA                   | USA                   | USA                   | USA                   | USA                   |
| Montgomery            | Montgomery            | Montgomery            | Montgomery            | Montgomery            | Montgomery            |
| Rockville             | Rockville             | Rockville             | Rockville             | Rockville             | Rockville             |
| Langley               | Langley               | Langley               | Langley               | Langley               | Langley               |
| Witty                 | Witty                 | Witty                 | Witty                 | Witty                 | Witty                 |
| 429 30 8076           | 429 30 8076           | 429 30 8076           | 429 30 8076           | 429 30 8076           | 429 30 8076           |
| Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner | Mrs. Emily M. Weisner |
| See item 13           | See item 13           | See item 13           | See item 13           | See item 13           | See item 13           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |   |  |   |   | REG. NO. 79-04689 |  |
|--|--|---|---|---|---|---|--|---|---|-------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   |   |   |  |   |   |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joseph (NMI) Horgan</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-8-79</b>                       |   |  | 2b. HOUR<br><b>7:35 P.M.</b>  |   |                   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH MONTH YEAR<br><b>Apr. 7, 1890</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.          |   |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>                         |  |   |   |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Health Center</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>(Ret) Dentist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dentistry</b>               |   |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   |   |   | 13b. COUNTY<br><b>Montg.</b>  |   | 13c. CITY OR TOWN<br><b>Bethesda</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Thomas Horgan</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Catherine Callahan</b> |   |  |   |   |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I 025-30-5488</b>   |   | 17. INFORMANT<br><b>Joseph T. Horgan</b>  |   |   | ADDRESS<br><b>Same as 13</b>   |   |   |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |   |   |   |   |   |  |   |   |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |   |   |   |  |   |   |                   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |   |   |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/7/77</b> , 19 <b>77</b> , to <b>Feb 8</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2/8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |  |   |   |                   |  |
| 22b. SIGNATURE<br><b>Michael Emmer</b>   |  |   |   |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/8/79</b>   |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Emmer</b>  |  |   |   |   | 22e. ADDRESS<br><b>10401 Old Georgetown Rd. Bethesda, Md.</b>           |   |  |   |   |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb. 12, 1979</b>                                   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cambridge Cem.</b>             |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Camb ridge, Mass.</b> |   |                   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1979</b>                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McNeely</b>   |   |   |                   |  |
| Homes, P.A. Bethesda, Md.  |  |   |   |   |   |   |  |   |   |                   |  |

BP

79-04689

Apr. 7, 1899

San Antonio

Mr.

San Antonio

Mr.

Mr.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5-6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 79-04690<br>REG. NO.  |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Eugene Joseph HOURIHANE |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2/7 1979   |  | 2b. HOUR<br>M<br>A:05   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 14, 1928   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>XX 50                  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2/7 1979  |  | 7d. HOUR<br>M<br>A:05   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D.C.  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>12609 Atherton Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERICAL   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>12609 Atherton Road  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EUGENE HOURIHANE   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GERTRUDE MILBURN                     |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II   |  |  |  | 16b. SOCIAL SECURITY NO.<br>579-40-1857   |  | 17. INFORMANT<br>ADDRESS<br>GERTRUDE HOURIHANE SAME AS 13 MOTHER                      |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Years                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br>None  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>None   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |  |  |  | TITLE (SPECIFY)<br>Deputy   |  |   |  | DATE SIGNED<br>2/7/79   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers, M.D.   |  |  |  | ADDRESS<br>1919 Seminary Road<br>Silver Spring, Montgomery, Md.   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  |  | 23b. DATE<br>2/9/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. OLIVET                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WASHINGTON, D.C.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS   |  |  |  | ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>                               |  |

00310-03

|     |    |            |                  |           |
|-----|----|------------|------------------|-----------|
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |
| YES | NO | 27-10-1957 | GERMINE INKIRANE | INTERVIEW |

500 UNIV. BLVD., ST. LOUIS, MO. 63101  
FRANCIS J. COLLINS  
2/9/59  
MR. OLIVER  
WASHINGTON, D.C.  
27-10-1957  
GERMINE INKIRANE  
INTERVIEW

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04691

|  |  |         |  |  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
|--|--|---------|--|--|--|------------------------------------|--|---|--|------------------|--|--|--|---------|--|---|--|------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST                               |  | 26. DATE KNOWN<br>OF DEATH  |  | MONTH            |  | DAY  |  | YEAR    |  | 2b. HOUR  |  |      |  |   |  |  |  |
| Norman.  |  | J       |  | Howard.  |  |                                    |  | 2-19-79   |  | 2-19-79          |  | 2-19-79  |  | 5:30    |  | M   |  |      |  |   |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 7c. DATE<br>PRONOUNCED<br>DEAD                           |  | MONTH   |  | DAY   |  | YEAR |  | 2d. HOUR  |  |  |  |
| M.   |  | W.      |  | 11-9-1912  |  | 66 YRS.                            |  | MONTHS  |  | DAYS             |  | 7-19-79  |  | 7-19-79 |  | 7-19-79   |  | 6P   |  | M   |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |         |  |   |  |      |  |   |  |  |  |
| Maryland   |  |         |  | U.S.A.   |  |                                    |  |   |  |                  |  | Montgomery   |  |         |  |   |  |      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |                  |  | 12b. KIND OF SCHOOL<br>OR INDUSTRY                       |  |         |  |   |  |      |  |   |  |  |  |
| Germantown.  |  |         |  | 19741 Blunt Rd   |  |                                    |  | Ret'd Employee  |  |                  |  | Montg. Co. Bd.   |  |         |  |   |  |      |  |   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  | 13a. STATE   |  |                                    |  | 13b. COUNTY   |  |                  |  | 13c. CITY OR TOWN  |  |         |  | 13d. INSIDE CITY LIMITS?                        |  |      |  | 13e. STREET ADDRESS   |  |  |  |
| Md.  |  |         |  | Montgomery   |  |                                    |  | Germantown  |  |                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |  | 19741 Blunt Rd.                                 |  |      |  |   |  |  |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME   |  |                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |                  |  | 16b. SOCIAL SECURITY NO.                                 |  |         |  | 17. INFORMANT                                   |  |      |  | ADDRESS   |  |  |  |
| Roy E. Howard  |  |         |  | Della Mae Redmond  |  |                                    |  | No -  |  |                  |  | 214-12-9230A   |  |         |  | Mrs. Lucille Howard                             |  |      |  | 19741 Blunt Rd.<br>Germantown, Md.                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.<br>402-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Hypertensive Cardiovascular Disease.<br>(c)  |  |         |  |  |  |                                    |  |   |  |                  |  |  |  |         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |      |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  | 20. AUTOPSY?  |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |                                    |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |  |  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)  |  |                                    |  | M.D.  |  |                  |  | MEDICAL EXAMINER   |  |         |  | DATE SIGNED                                     |  |      |  |   |  |  |  |
| John S. Bell   |  |         |  | Deputy   |  |                                    |  |   |  |                  |  |  |  |         |  | Feb-27-1979                                     |  |      |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |         |  | ADDRESS  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |         |  | 23b. DATE  |  |                                    |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION<br>CITY OR TOWN                            |  |         |  | COUNTY  |  |      |  | STATE   |  |  |  |
| Burial   |  |         |  | 2/23/79  |  |                                    |  | Neelsville Presby. Ch. Cem.   |  |                  |  | Germantown   |  |         |  | Montgomery                                      |  |      |  | Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                    |  | 25b. REGISTRAR'S SIGNATURE  |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| Gartner-Sandison F. H.   |  |         |  | FEB 28 1979  |  |                                    |  | Murray McCready   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                    |  | 25b. REGISTRAR'S SIGNATURE  |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |
| Gartner-Sandison F. H.   |  |         |  | FEB 28 1979  |  |                                    |  | Murray McCready   |  |                  |  |  |  |         |  |   |  |      |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                      |   |   |  |  |  |  | 79-04692  |  |
|--|--|--|----------------------|---|---|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |                      |   |   |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ERNEST R. JACKSON   |  |  |                      |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/6/79                   |  |  | 2b. HOUR<br>3:39 A.M.  |  |   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>BLACK  |                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 18 02   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |                      |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FARMER           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY  |                      | 13c. CITY OR TOWN<br>WASH. D.C.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>56 R St. N.E.   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest JACKSON   |  |  |                      |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Effie BRACKETT |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |                      | 16b. SOCIAL SECURITY NO.<br>218-30-4619   |   | 17. INFORMANT<br>ADDRESS<br>CLARSEY JACKSON - 56 R. St. N.E.<br>WASH. D.C.           |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Acute Myocardial Infarction<br>410- DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary occlusion<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Atherosclerotic Cardiovascular disease |  |  |                      |   |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                      |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 1 June 1978, to 6 Feb 1979, that (we) last saw the deceased alive on 6 Feb 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                      |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Thomas P. Fogarty M.D.   |  |  |                      |   |   |  |  |  |  | 22c. DATE SIGNED<br>6 Feb 79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas P. Fogarty M.D.  |  |  |                      |   |   |  |  |  |  | 22e. ADDRESS<br>7676 New Hampshire Ave - Langley Park Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2-10-79 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.        |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Montg Md.                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George R. Snowden  |  |  |                      |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |



12-04885

BM

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04693

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>John H. JENKINS, SR.  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 27 1979    |  |   | 2b. HOUR<br>620P M   |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 7 1896  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83<br>YRS MONTHS DAYS  |  | 7 IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Oregon  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Navy                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>D. C. |  |  | 13b. COUNTY<br>Washington                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2900 Connecticut Ave. N.W. / Apt. 142 |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Temple Jenkins  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Hayes |  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes 1917-1946 |  |  |  |
| 16b SOCIAL SECURITY NO.<br>578 58 8007  |  |  | 17 INFORMANT<br>John H. Jenkins Jr.                        |  |   | ADDRESS Bethesda, Md.<br>5306 Worthington Dr.  |  |  |  |

|  |  |  |  |
|--|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive hemoptysis</u><br><u>1629</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Widespread squamous cell cancer of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Feb. 7</u> , 19 <u>79</u> to <u>Feb. 27</u> , 19 <u>79</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>B. Chernow, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>            |  |  |  |  |  | 22c. DATE SIGNED<br>Feb. 28, 1979  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>B. Chernow, M.D.</u>  |  |  |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md                          |  |  |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br><u>3-5-79</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Arlington Va. |  |
| 24. FUNERAL DIRECTOR<br>DeVol Funeral Home             |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 7 1979              |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-04803



February 1950

January 1950

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Washington

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National Naval Medical Center

U.S. Navy

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1015-1942 John H. Johnson Jr. 1015-1942

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Washington

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04694

|   |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
|---|---------|------------------|---|----------------|------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | FIRST MIDDLE LAST   |                |                  | 2a. DATE KNOWN OF DEATH  |  |  | X MONTH DAY YEAR  |  |  | 2b. HOUR   |  |  |
| Margaret Frances Jenkins  |         |                  |   |                |                  | 2-19 1979  |  |  | 5:55 P.M.   |  |  |  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD   |  |  | MONTH DAY YEAR  |  |  | 2d. HOUR   |  |  |
| Female  | White   | 10-20-10         | 68 YRS.   |                |                  | 2-19- 1979   |  |  | 5:55 P.M.   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                                |                |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  | MD.  |  |  |
| D.C.  |         |                  | U.S.A.  |                |                  |  |  |  | MONTGOMERY  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  | U.S. Catholic Conf   |  |  |
| BETHESDA  |         |                  | SUBURBAN HOSPITAL   |                |                  | Secretary  |  |  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |                  | 13b. CITY OR TOWN   |                |                  | 13d. INSIDE CITY LIMITS?   |  |  | 13e. STREET ADDRESS   |  |  |  |  |  |
| Md. Montgomery  |         |                  | Rockville   |                |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 299 Hurley Ave.   |  |  |  |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME                                    |                |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS                                      |  |  |
| Phillip H. Jenkins  |         |                  | Daisey M. Gray  |                |                  | No   |  |  | 579-44-1455   |  |  | Chevy Chase, Md. Kathryn Gorman, Sister. 4515 Willard Ave. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |   |                |                  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |  |
| PART I DEATH WAS CAUSED BY:   |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio-Respiratory Failure.   |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| (b) Cardio-Vascular Disease.  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| (c) Generalized Arterio Sclerosis.  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| Fracture of Left Hip & Humerus - Hyperkeratosis of Esophagus  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                |                  | 20. AUTOPSY?   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |
|   |         |                  | P.M. 2-1-79   |                |                  | Fallen Nursing Home.   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                |                  | 21f. LOCATION  |  |  | CITY OR TOWN  |  |  | COUNTY   |  |  |
|   |         |                  | Nursing Home - Collingwood                                  |                |                  | Rockville  |  |  | Mont.   |  |  | Md.  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE  |         |                  | TITLE (SPECIFY)   |                |                  | DATE SIGNED  |  |  |   |  |  |  |  |  |
| John G. Ball  |         |                  | M.D. Deput  |                |                  | 2/20/79  |  |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |                  | ADDRESS   |                |                  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY                         |  |  |
| John G Ball, M.D.   |         |                  | 7936 Old Georgetown Rd., Bethesda, Md.                      |                |                  | Burial   |  |  | 2/23/1979   |  |  | Mt. Olivet Cemetery  |  |  |
| 23d. LOCATION   |         |                  | 23e. DATE REC'D. BY REGISTRAR                               |                |                  | 23f. REGISTRAR'S SIGNATURE   |  |  |   |  |  |  |  |  |
| Washington, D.C.  |         |                  | FEB 28 1979   |                |                  | History & Brandy   |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |         |                  | 25a. DATE REC'D. BY REGISTRAR                               |                |                  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |  |  |  |
| JOSEPH CAWLER'S SONS INC.   |         |                  | FEB 28 1979   |                |                  | History & Brandy   |  |  |   |  |  |  |  |  |
| 8124 WISC. AVE., N. W. WASH., D. C. 20018   |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10340-05

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Melvin W. A. Jenkins, Jr.</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>20</b> YEAR <b>79</b>   |  | 2b. HOUR<br><b>11:45</b> AM   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> -DAY <b>3</b> -YEAR <b>1955</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>23</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | 7b. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                             |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD   |  | 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b>   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br><b>817 Anderson St., S.S. Md.</b>  |  |
| 13b. STATE<br><b>MD.</b>   |  | 13c. CITY OR TOWN<br><b>P.G. Monte Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Melvin</b> MIDDLE <b>W.</b> LAST <b>Jenkins, Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ida</b> MIDDLE <b>Clark</b> LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>578-46-5142</b>   |  | 17. INFORMANT<br><b>Ida Jenkins</b>  |  | 17. ADDRESS<br><b>817 Anderson St. S.S. Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possibly aspirated pneumonia, massive</b><br><b>3319</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Terminal Progressive cerebellar degeneration years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/20/79</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1978</b> 19 <b>2/20/79</b> 19 <b>2/20/79</b> , that (I) (we) lost saw the deceased alive on <b>Jan 1979</b> 19 <b>2/20/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>2/20/79</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. OTH LERAGUL MD</b>   |  | 22e. ADDRESS<br><b>7425 Arlington Rd, Bethesda Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-24-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Mem. Cem.</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME <b>Johnson &amp; Carlson</b> ADDRESS <b>746 Kennedy St</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 01 1979</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Parkway/Kelley</b>  |  |  |  |   |  |

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2-24-55

Severin



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                  |  |  |   |  |  |   |  |  |
|--|------------------|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |                  | 79-04696   |  |   |  | REG. NO.   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  |  | FIRST MIDDLE LAST<br>GEORGE FRANKLIN JEWELL                            |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 22 1979  |   |  | 2b. HOUR<br>7:00 AM                          |
| 3. SEX<br>M  | 4. RACE<br>CAUC. | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV 13, 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3000 SHANANDALE DRIVE |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AUTO MECHANIC  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |                  |  | 13b. COUNTY<br>MONTGOMERY  |   | 13c. CITY OR TOWN<br>SILVER SPRING   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3000 SHANANDALE DRIVE |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRISON B. JEWELL   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH A. UNKNOWN      |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |                  |  | 16b. SOCIAL SECURITY NO.<br>578-05-1223                                |   | 17. INFORMANT<br>ADDRESS<br>JOSEPHINE MARY JEWELL SAME AS 13 WIFE              |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Arteriosclerotic heart disease</u><br>(c) <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |                  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HOURS<br>YRS<br>YRS.   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUG-26</u> , 19 <u>77</u> , to <u>FEB-22</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased above, <u>JAN-19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Albert H. Grollman MD</u>   |                  |  | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/23/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALBERT H. GROLLMAN  |                  |  | 22e. ADDRESS<br>1106 S. MOUNTAIN ST. SILVER SPRING MD.                 |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |                  |  | 23b. DATE<br>2/24/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>FT. LINCOLN                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BRENTWOOD PRI GEO MD.                             |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br>FRANCIS J. COLLINS  |                  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1979                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCready  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |                  |  |  |   |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO. 79-04697  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Isabelle D. Johnson</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2/19/79</b>  |  | 2b. HOUR<br><b>7:00</b> AM  |  |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7 09 06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> <b>SEPARATED</b> <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>operator</b>                      |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1406 Thornden Road</b>                          |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unknown Westbay</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>A Joyce Klinger same as 13e</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>intermittent congestive heart failure</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>mitral insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>arteriosclerotic heart disease</b>      |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b><br><b>3 yrs</b><br><b>years</b>                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>no other</b>  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Feb 5</b> 19 <b>70</b> to <b>Feb 12</b> 19 <b>79</b> , that (1) we last saw the deceased alive on <b>Feb 16</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; and (2) (did/did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bowditch Hunter</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |  |   |  | 22c. DATE SIGNED<br><b>2/20/79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bowditch Hunter</b>  |  |   |  | 22e. ADDRESS<br><b>Rockville Pike Rockville, Md.</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/22/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Tyson Wheeler Funeral Home, Rockville, Maryland</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |  |  |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                     |  |   |  |  |  |   |  |   |  | REC. NO. 79-04698   |  |                                       |  |   |  |  |  |
|--|--|---------------------|--|---|--|--|--|---|--|---|--|---|--|---------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Charles Herman Kalons</i>  |  |                     |  |   |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <i>Feb 21 1979</i> |  | 7b. HOUR<br><i>4:20 A.M.</i>          |  |   |  |  |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>W</i> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>NOV 25, 1894</i>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>84 YRS</i> |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br><i>Feb 21 1979</i>                                      |  | 7d. HOUR<br><i>4:21 A.M.</i>  |  |                                       |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>WISCONSIN</i>  |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                               |  |                                       |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Sil. Spg.</i>  |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>204 E Franklin Ave</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>BRICKMASON</i>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                       |  |   |  |  |  |
| 13a. STATE<br><i>MD</i>  |  |                     |  |   |  |  |  |   |  |   |  | 13b. COUNTY<br><i>Mont.</i>   |  | 13c. CITY OR TOWN<br><i>Sil. Spg.</i> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>204 E Franklin Ave</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>JOHN KALONS</i>   |  |                     |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>JESSICA KAMINSKY</i>     |  |   |  |   |  |   |  |                                       |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>YES WW I</i>   |  |                     |  | 16b. SOCIAL SECURITY NO.<br><i>178-05-7808</i>  |  |  |  | 17. INFORMANT<br>ADDRESS<br><i>AGNES D. KALONS SAME AS 13 WIFE</i>  |  |   |  |   |  |                                       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial D.</i><br><i>4291</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Chronic Myocardial Dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Krs.</i>  |  |                     |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                       |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>None</i>   |  |                     |  |   |  |  |  |   |  |   |  |   |  |                                       |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |                                       |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |                                       |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                       |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                     |  |   |  |  |  |   |  |   |  |   |  |                                       |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |  |                     |  | TITLE (SPECIFY)<br><i>Dep.</i>  |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><i>Feb 21 1979</i>   |  |                                       |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>JOHN S. ROGERS</i>  |  |                     |  | ADDRESS<br><i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>  |  |  |  |   |  |   |  |   |  |                                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  |                     |  | 23b. DATE<br><i>2/24/79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>gate of Heaven</i>                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Silver Spring, Montgomery, Md.</i> |  |   |  |                                       |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANCIS J. COLLINS</i>  |  |                     |  | 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><i>FEB 27 1979</i>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>  |  |                                       |  |   |  |  |  |

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YES NO I 171-02-1108 JAMES D. KALING SAME AS 13 THE

1917 CENTURY ROAD SILVER SPRING MD.

JOHN S. ROGERS

1917 CENTURY ROAD SILVER SPRING MD.

State of Maryland

3/14/79

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200 WITH SEND TO SILVER SPRING MD. 20001

Items #10a Film G529 3/30/79 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04699

|  |  |                      |  |  |  |  |  |   |  |   |  |   |  |                                   |  |
|--|--|----------------------|--|--|--|--|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Elizabeth   |  | MIDDLE<br>W.   |  | LAST<br>Kast   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2 21 19 79   |  |   |  | 2b. HOUR<br>M<br>7:15 A. M  |  |                                   |  |
| 3. SEX<br>female   |  | 4. RACE<br>white     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 25, 1921   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>57  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 21 19 79    |  | 7d. HOUR<br>A. M  |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Alexandria, Va.   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Mont Co. MD.                                |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>at home/913 Clopper Road |  |  |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sec. E.G. & G.     |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                      |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Mont. |  | 13c. CITY OR TOWN<br>Gaithersburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>913 Clopper Rd.  |  |   |  |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John D. Worsham  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruby Bunch                          |  |   |  |   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |  |                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>230-07-4875   |  | 17. INFORMANT<br>ADDRESS<br>Frank C. Kast Jr same as 11                              |  |   |  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fatty Liver and acute pyelonephritis</b><br>5718<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |  |  |  |  |   |  |   |  |   |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |  |  |   |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |   |  |   |  |   |  |                                   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                      |  | TITLE (SPECIFY)<br>Assistant   |  |  |  | DATE SIGNED<br>2/22/79  |  |   |  |   |  |                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                      |  | ADDRESS<br>111 Penn Street, Balto. MD 21201  |  |  |  |   |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial   |  |                      |  | 23b. DATE<br>2-26-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                            |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md. |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Everly-Wheatley  |  |                      |  | ADDRESS<br>1500 W. Braddock Rd. Alex., Va.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>         |  |   |  |                                   |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | REG. NO. 79-04700  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
| 1- STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LISA Michelle KEELING</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 2 5 1979 |  |
| 3. SEX <b>female</b> 4. RACE <b>black</b> 5. DATE OF BIRTH <b>Aug. 15 63</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>15</b> YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |  |  |  |  |  | 2b. DATE PRONOUNCED DEAD <b>2 5 19 79</b> 2c. HOUR <b>4:10</b> P M               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D. C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b> 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>S.S.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>12808 Broadmoore Rd.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Keeling</b> LAST <b>Ann</b> 15. MOTHER'S MAIDEN NAME FIRST <b>Ann</b> MIDDLE <b>Noble</b> LAST  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>--</b> 17. INFORMANT <b>James Keeling Father</b> ADDRESS <b>Same as above</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Subacute meningoencephalitis</b><br>IMMEDIATE CAUSE (a) <b>048-</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>2/6/79</b>  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street, Balto., MD 21201</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>2/10/79</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery S.S.</b> 23d. LOCATION CITY OR TOWN <b>Mont.</b> STATE <b>Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b> ADDRESS <b>11800 N.H.Ave. S.S. Md.</b> 25a. DATE RECEIVED BY REGISTRAR <b>FEB 13 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |  |  |  |  |  |  |  |  |

19-04100

Aug. 12 1979

USA

Student

12808 Thompson Ave.

X

S.S.

Mont.

Ms.

Boyle

Ann

Keeling

James Keeling

James Keeling Teacher as above

No

Keeling/James E.H. 12808 N.H. Ave. S.S. Ms.

Gate of Heaven Cemetery S.S. Mont. Ms.

Burial

5/10/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04701

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Helen J. Kell  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 18 79                               |  | 2b. HOUR<br>7:37p  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 9 1911  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Spring  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edmund Carhart Dillon  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret McCourt             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no none  |  | 16b. SOCIAL SECURITY NO.<br>212-22-2004  | 17. INFORMANT<br>ADDRESS<br>Peter E. Kell, Sr. - husband - (same as 13)       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiogenic shock</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>b. <u>myocardial infarction</u><br>c. <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>(e)  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13/79</u> to <u>2/18/79</u> , 19 <u>79</u> , that (I) (we) saw the deceased alive on <u>2/18/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Pasquale Perrino</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Pasquale Perrino, MD.   |  | 22e. ADDRESS<br>15 E. Deerpark, Gaithersburg, Md.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>2-23-79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Upper Darby Delaware Pa.               |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.  |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 23 1979   |   |  |  |

10540-01

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 79-04702   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Veronica S. Keller</u>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <u>2</u> DAY <u>1</u> YEAR <u>79</u>   |  |  |  | 2b. HOUR<br><u>9:59</u> A.M.   |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>2</u> DAY <u>16</u> YEAR <u>01</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>27</u> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS <u>7</u> DAYS <u>17</u>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <u>D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring Md</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Holy Cross Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Cataloger</u>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Catholic Univ.</u>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>md</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Silver Spring</u>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><u>3611 Hewitt Avenue</u>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>Camillus</u> MIDDLE <u>Wood</u> LAST <u>Wood</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Mary</u> MIDDLE <u>Ann</u> LAST <u>Rabbit</u>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><u>577-09-1204</u>  |  | 17. INFORMANT <u>friend</u> ADDRESS<br><u>Joan A. Shorb 4810 Listra Dr. Rockville, Md.</u> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypovolemic septic shock</u><br><u>5334</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>bleeding perforated ulcer</u><br>(c) <u>perforated ulcer disease</u> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u><br><u>longer than 3 wks.</u>                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Centros 7 the liver causes 2° alcoholism</u>   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>1/31/79</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>perforated ulcer</u>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>79</u> , to <u>2/1</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>2/1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.      |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Veronica S. Keller</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><u>2/1/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. E. Keller</u>  |  |   |  | 22e. ADDRESS<br><u>911 S.L. Spc. Rd.</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>  |  | 23b. DATE<br><u>Feb. 3, 1979</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Silver Spring Mont. Md.</u>               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Francis J. Collins</u> ADDRESS<br><u>500 University Blvd., W. Silver Spring, Md.</u>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 9 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>                                      |  |  |  |

50-01505



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | REG. NO. 79-04703  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY T Kelly  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 1 79  |  | 2b. HOUR<br>7:05 A M                                       |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>3 8 08   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Rockville   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6 Cedar Court  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Albert Y. Tucker  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ethel Whitney  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>080 20 5408   |  | 17 INFORMANT<br>Margaret T. Duffy  |  |  |  | ADDRESS<br>same as item 13  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Sudden Pulmonary disease</u><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CHF</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>yes</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerosis of Brain</u>   |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>2-1-79</u> to <u>2-2-79</u> , that (1) (was) lost saw the deceased alive on <u>2-1-79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) (was) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c. DATE SIGNED<br>2/2/79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dohr S. SAIA MD  |  |   |  | 22e. ADDRESS<br>806 Viers Mill Rd. Rockville Md.   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/6/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pinelawn Cemetery  |  | 23d. LOCATION<br>Long Island New York STATE  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE MARYLAND  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>FEB 7 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |  |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-440888) FROM : SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR TRIP TO AFRICA

RE: NEW YORK TELETYPE TO BUREAU, 1/11/68.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON 1/10/68, JAMES EARL RAY, AKA, ADVISED THAT HE HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM A PASSPORT FOR A TRIP TO AFRICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM A PASSPORT FOR A TRIP TO AFRICA.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04704

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lawrence Alvin Kerns</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 02 04 79</b>  |  | 2b. HOUR P<br><b>11:04 M</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 29 1931</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>47</b>              |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wash. Adventist Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postal Supervision</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Md. PG Beltsville</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Avner S. Kerns</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Kelley</b>                             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 26 0099</b>  |   | 17. INFORMANT <b>Same as above</b><br><b>Shirley L. Kerns (Wife)</b>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Mitral Regurgitation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rheumatic Heart Disease</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>10 yrs</b><br><b>10 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>72</b> , to <b>Jan</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Keith M. Lindgren MD</b>  |  |   |   | 22c. DATE SIGNED<br><b>2/4/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Keith Lindgren</b>   |  |   |   | 22e. ADDRESS<br><b>7600 Carroll Ave. T.P. Md.</b>                              |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/7/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery Brentwood PG</b> |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>H/R Funeral Home 11800 N.H. Ave. Silver Spring, Md.</b>  |   |  |   |
| 25a. DATE RECD. BY REGISTRAR   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>FEB 7 1979</b>                                |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |   |   |                                    |   |  |   |                                    | 79-04705  |  |
|---|--|------------------------------|---|---|------------------------------------|---|--|---|------------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |                              |   |   |                                    |   |  |   |                                    | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST <b>OSIE</b> MIDDLE <b>R.</b> LAST <b>KETTENBACH</b>   |   |                                    | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   | 2b. HOUR                           |   |  |
| <b>OSIE R. KETTENBACH</b>   |  |                              |   |   |                                    | <b>2/12/79</b>  |  |   | <b>6:20 P.M.</b>                   |   |  |
| 3. SEX  |  | 4. RACE                      |   | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |                                    | IF UNDER 24 HRS                                 |  |
| <b>Female</b>   |  | <b>White</b>                 |   | <b>Sept. 28, 1895</b>   |                                    | <b>83</b> YRS   |  | MONTHS DAYS   |                                    | HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   | MD.                                |   |  |
| <b>Virginia</b>   |  | <b>U.S.A.</b>                |   |   |                                    | <b>Montgomery</b>   |  |   |                                    |   |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| <b>Bethesda</b>   |  |                              | <b>SUBURBAN HOSPITAL</b>  |   |                                    | <b>Homemaker</b>  |  |   | <b>Home</b>                        |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |   |   |                                    |   |  |   |                                    |   |  |
| 13a. STATE  |  | 13b. COUNTY                  |   | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |                                    |   |  |
| <b>Maryland</b>   |  | <b>Montgomery</b>            |   | <b>Rockville</b>  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | <b>199 Rollins Ave.</b>   |                                    |   |  |
| 14. FATHER'S NAME   |  |                              |   |   |                                    | 15. MOTHER'S MAIDEN NAME  |  |   |                                    |   |  |
| FIRST MIDDLE LAST   |  |                              |   |   |                                    | FIRST MIDDLE LAST   |  |   |                                    |   |  |
| <b>William Butler</b>   |  |                              |   |   |                                    | <b>Mary A. Grisby</b>   |  |   |                                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |                              |   | 16b. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT ADDRESS   |  |   |                                    |   |  |
| <b>No</b>   |  |                              |   | <b>578-10-3625</b>  |                                    | <b>Carl Kettenbach, Husband, Same as item 13</b>  |  |   |                                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular arrest - stone</u><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerosis</u><br>2 weeks<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arterio-sclerotic Vase. Disease &amp; CVA</u><br>1 yr           |  |                              |   |   |                                    |   |  |   |                                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Probable massive Thrombosis -</u>  |  |                              |   |   |                                    |   |  |   |                                    |   |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                    | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                                    |   |  |
|   |  |                              |   |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                    |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/12/79</u> 19 <u>79</u> , to <u>2/12/79</u> 19 <u>79</u> , that (I) (we) last<br>saw the deceased alive on <u>2/12/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                              | 22b. SIGNATURE<br><u>Stephen N. Jones</u><br>DEGREE   |   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>2/12/79</u> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              | 22e. ADDRESS  |   |                                    |   |  |   |                                    |   |  |
| <b>Stephen N. Jones</b>   |  |                              | <b>Rockville, Md. 20851</b>   |   |                                    |   |  |   |                                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |                              | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |                                    |   |  |
| <b>Burial</b>   |  |                              | <b>2/16/1979</b>  |   | <b>Parklawn Memorial Park</b>      |   |  | <b>Rockville, Maryland</b>  |                                    |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |                              | JOSEPH CAWLER'S SONS INC.<br>ADDRESS  |   |                                    | 25. REGISTRAR'S SIGNATURE   |  |   |                                    |   |  |
| <b>5130 WISQ. AVE., N. W. WASH., D. C. 20016</b>  |  |                              |   |   |                                    |   |  |   |                                    |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |   |   |   | REG. NO. 79-04706                                     |  |  |
|---|--|--|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>SANG WOOK KIM</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>21</b> YEAR <b>79</b>                |  |   | 2b. HOUR <b>12</b> AM <b>PM</b>   |   |   |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>oriental</b>  |  | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>28</b> YEAR <b>22</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS                                  |   | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                                      |   | 7b. IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Korea</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>Korea</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                     |   |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b> |  |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>self employed</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b> |  |  |
| 13a. STATE <b>Maryland</b>  |  |  |  |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Rockville</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS <b>1602 Grandin Avenue</b> |  |
| 14. FATHER'S NAME FIRST <b>Kwang</b> MIDDLE <b>Yun</b> LAST <b>Kim</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Chong</b> MIDDLE <b>Bo</b> LAST <b>Ham</b> |  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>220-78-4642</b>  |  | 17. INFORMANT ADDRESS <b>Kum Ja Kim same as 13e</b>                            |   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hepatic Coma &amp; Failure</b><br><b>5723</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Jauundice</b><br>(c) <b>Portal Hypertension</b>                      |  |  |  |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>3</b> YEAR <b>79</b> |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  |  | 21f. LOCATION STREET <b>Suburban Hospital Bethesda Md.</b>                     |   | CITY OR TOWN  |   | COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 3</b> 19 <b>79</b> , to <b>Feb 21</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Feb 21</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE <b>Boo K. Kim</b> DEGREE <b>MD</b>   |  |  |  |  |  | 22c. DATE SIGNED <b>FEB 21, 1979</b>   |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Boo K. Kim</b>   |   |  |  |
| 22e. ADDRESS <b>Suburban Hospital Bethesda Md.</b>  |  |  |  |  |  |  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  | 23b. DATE <b>2/23/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Norbeck Memorial Park</b>              |  |   | 23d. LOCATION CITY OR TOWN <b>Norbeck</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b> |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>   |  |  |  |  |  | 25a. DATE RECD. BY REGISTRAR <b>FEB 26 1979</b>                                |   |   |   |   |  |  |
| 1331 Rockville Pike Rockville, Md. 20852  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                  |   |   |   |   |  |  |



13-01106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 11 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Released by Dr. Mayer

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-04707   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Joseph M. Kingsbury</b>   |  |   |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>23</b> YEAR <b>79</b> 2b. HOUR <b>10</b> <sup>58</sup> <sub>M</sub>   |  |   |  |
| 3 SEX <b>MALE</b>   |  | 4 RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>Oct</b> DAY <b>6</b> YEAR <b>1893</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH <b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Third Federal Nat. Ins. Co.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montg.</b>  |  | 13c. CITY OR TOWN <b>Washington</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>10031 Frederick Ave.</b>   |  |
| 14 FATHER'S NAME (TYPE OR PRINT) <b>Charles F. Kingsbury</b>  |  | 15 MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Nice Reid</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>220-44-6031</b>   |  | 17. INFORMANT (TYPE OR PRINT) <b>Hermane O'Connell (Daughter)</b> ADDRESS <b>13e</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic renal failure (Uremia)</b> 2500  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetic nephropathy</b> 5425   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> 25425.  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> YEAR <b>1975</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET <b>1975</b> CITY OR TOWN <b>1975</b> COUNTY <b>1975</b> STATE <b>1975</b>  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> 19 <b>2/23/79</b> to <b>2/23/79</b> 19 <b>2/23/79</b> , that (I) (we) last saw the deceased alive on <b>2/23/79</b> 19 <b>2/23/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE (TYPE OR PRINT) <b>George C. Longshore</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED <b>2/24/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Feb. 27-1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>  |  | 23d. LOCATION CITY OR TOWN <b>Bethesda</b> COUNTY <b>Montg.</b> STATE <b>MD.</b>  |  |
| 24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>Arthur Walters</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>  |  |

70740-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |   |   |  |  |
|--|--|---|--|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 79-04708   |  |  |   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>John Henry KISNER  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-26-79                                       |  |   | 2b. HOUR MIN<br>5:30 PM   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6/10/09   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.                               |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County D.             |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Plumber |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plumbing                           |  |  |
| 13a. STATE<br>Maryland   |  |   |  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Rockville  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Christopher Kisner  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Isabel Knight                       |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>579-07-0756   |  | 17. INFORMANT ADDRESS<br>Nellie A. Kisner, same as #13   |   |  |   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CARCINOMA   |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>1 day<br>1 mo |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18, 19 79, to 2/26, 19 79, that (I) (we) last saw the deceased alive on 2/26, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Daniel Rosenblum MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |   |  | 22c. DATE SIGNED<br>2/27/79   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DANIEL ROSENBLUM  |  |   |  | 22e. ADDRESS<br>10900 CONNECTICUT AV KENSINGTON, MD 20795  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/2/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Potomac United Methodist   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Potomac MD                    |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>Robert A. Pumphrey Funeral Homes, P. 300 W. Montgomery Ave., Rockville, MD   |  |   |  |  |   |  |   |   |  |  |

80710-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04709

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>SAMUEL XXX KLUGMAN  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-1-79  |  | 2b. HOUR<br>4P M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2-13-93  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CO. MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA, MD.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL                       |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MEN'S CLOTHING DESIGNER                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>POTOMAC   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>11128 POWDERHORN DR. POTOMAC, MD. 20854   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>349-05-8505A   |  | 17. INFORMANT<br>MRS. PAUL GOODMAN 1 SLADE AVE., APT. 305 #21208   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Relational Pneumonia</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic Cardiovascular disease</u> 10 YRS<br>(c) <u>Arterio Sclerotic Bleeding</u> UNKNOWN CAUSE 10 YRS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>act.</u> 19 <u>78</u> , to <u>2/1/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/1/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Lawrence J. Thomas MD.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/1/79   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LAWRENCE J. THOMAS  |  | 22e. ADDRESS<br>11801 ROCKVILLE PIKE   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>FEB. 4, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 6 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Pietro McCreedy  |  |  |  |   |  |

MEDICAL CERTIFICATION

99

1

6001

92-64702



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |  |  |  |  | REG. NO. 79-04710  |  |
|---|--|------------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Frederick Lewis Knapp   |  |                  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br>2 21 1979  |  | 2b. HOUR<br>7 30 AM  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>NOV 25 - 1955  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>23 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>7 26 - 21 1979                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Moving Man  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>House                                       |  |
| 13a. STATE<br>MARYLAND  |  |                  |  | 13b. COUNTY<br>P.B. Co.   |  | 13c. CITY OR TOWN<br>LAUREL  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>322 PRINCE GEORGE ST.                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FREDERICK KNAPP  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH ANN KELLER   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>214-70-3367   |  | 17. INFORMANT ADDRESS<br>Elizabeth A. Knapp same as #8 13  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 8147 Multiple Injuries - Severe<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Trauma from Auto Accident -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>6 50 A.M. 2 - 21 1979   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Struck by Truck skidding on Ice |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Near beach Highway                                   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Rd. Rockyville Montgomery Md.                               |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion   |  |                  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>John S. Ball  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED 7 26 24 1979   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |                  |  | ADDRESS   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>2/24/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Laurel, Prince Geo. Md.               |  |
| 24. FUNERAL DIRECTOR<br>FLECK LAUREL FUNERAL HOME, INC.<br>7601 Sandy Spring Rd. Laurel, Md. 20810  |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Fitzroy McLeod   |  |  |  |

19-0110

REG. NO. 79-04711

1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                               |  | LAST   |  | 2. DATE OF DEATH  |  | 3. DAY  |  | 4. MONTH  |  | 5. YEAR   |  | 6. HOUR  |  |
| Louis   |  | D.   |  | Krakow  |  | 2   |  | 6   |  | 79  |  | 10 <sup>22</sup> AM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                 |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS  |  | 9. MONTHS  |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR<br>SEPT. 7 1899  |  | 79  |  | YRS.  |  | MONTHS  |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH            |  | 10. MD  |  | 11. IF UNDER 1 YEAR   |  | 12. IF UNDER 24 HRS  |  |
| MARYLAND  |  | U.S.A.   |  |   |  | montgomery                                      |  |   |  | MONTHS  |  | DAYS   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  | 13. STREET ADDRESS  |  | 14. CITY OR TOWN  |  | 15. STATE  |  |
| TAKOMA PARK   |  | WASHINGTON ADVENTIST HOSPITAL  |  | FOOD BROKER   |  | FOOD  |  | 1020 HEATHER AVENUE   |  | TAKOMA PARK   |  | MARYLAND   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. ADDRESS                                     |  | 19. CITY OR TOWN  |  | 20. STATE   |  | 21. ZIP CODE   |  |
| YES   |  | 577-03-1575A   |  | ROSE KRAKOW   |  | (SAME AS #13)                                   |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 13a. COUNTY   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS                             |  | 13e. CITY OR TOWN   |  | 13f. STATE  |  | 13g. ZIP CODE  |  |
| MONTGOMERY  |  | TAKOMA PARK  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1020 HEATHER AVENUE                             |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. DATE OF OPERATION   |  | 17. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 18. AUTOPSY?  |  | 19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 20. YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| MAX   |  | VETTA  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. ADDRESS                                     |  | 19. CITY OR TOWN  |  | 20. STATE   |  | 21. ZIP CODE   |  |
| YES   |  | 577-03-1575A   |  | ROSE KRAKOW   |  | (SAME AS #13)                                   |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 13a. COUNTY   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS                             |  | 13e. CITY OR TOWN   |  | 13f. STATE  |  | 13g. ZIP CODE  |  |
| MONTGOMERY  |  | TAKOMA PARK  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1020 HEATHER AVENUE                             |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. DATE OF OPERATION   |  | 17. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 18. AUTOPSY?  |  | 19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 20. YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| MAX   |  | VETTA  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. ADDRESS                                     |  | 19. CITY OR TOWN  |  | 20. STATE   |  | 21. ZIP CODE   |  |
| YES   |  | 577-03-1575A   |  | ROSE KRAKOW   |  | (SAME AS #13)                                   |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 13a. COUNTY   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS                             |  | 13e. CITY OR TOWN   |  | 13f. STATE  |  | 13g. ZIP CODE  |  |
| MONTGOMERY  |  | TAKOMA PARK  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1020 HEATHER AVENUE                             |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. DATE OF OPERATION   |  | 17. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 18. AUTOPSY?  |  | 19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 20. YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| MAX   |  | VETTA  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. ADDRESS                                     |  | 19. CITY OR TOWN  |  | 20. STATE   |  | 21. ZIP CODE   |  |
| YES   |  | 577-03-1575A   |  | ROSE KRAKOW   |  | (SAME AS #13)                                   |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 13a. COUNTY   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS                             |  | 13e. CITY OR TOWN   |  | 13f. STATE  |  | 13g. ZIP CODE  |  |
| MONTGOMERY  |  | TAKOMA PARK  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1020 HEATHER AVENUE                             |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. DATE OF OPERATION   |  | 17. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 18. AUTOPSY?  |  | 19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 20. YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| MAX   |  | VETTA  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. ADDRESS                                     |  | 19. CITY OR TOWN  |  | 20. STATE   |  | 21. ZIP CODE   |  |
| YES   |  | 577-03-1575A   |  | ROSE KRAKOW   |  | (SAME AS #13)                                   |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 13a. COUNTY   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS                             |  | 13e. CITY OR TOWN   |  | 13f. STATE  |  | 13g. ZIP CODE  |  |
| MONTGOMERY  |  | TAKOMA PARK  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1020 HEATHER AVENUE                             |  | TAKOMA PARK   |  | MARYLAND  |  | 20910  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. DATE OF OPERATION   |  | 17. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 18. AUTOPSY?  |  | 19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 20. YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| MAX   |  | VETTA  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO             |  |  |  |   |  |   |  |   |  |   |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11710-02

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |         |  |   |  |                                    |  |  |  | REG. NO. 79-04712   |  |                                      |  |
|--|--|---------|--|---|--|------------------------------------|--|--|--|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |         |  |   |  |                                    |  |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ingeborg Wilhelmine Kremnitzer   |  |         |  |   |  |                                    |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2/4 1979 |  | 2b. HOUR M<br>11:04 P.M.             |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)    |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR                             |  |
| Female   |  | White   |  | Sep. 6, 1920  |  | 58 YRS.                            |  |  |  | 2/4 1979  |  | P.M.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
| Czechoslovakia   |  |         |  | USA   |  |                                    |  |  |  |   |  | Montgomery County MD                 |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| Takoma Park  |  |         |  | Washington Adventist Hospital   |  |                                    |  | Nurse  |  |   |  | US Govt.                             |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |   |  |                                    |  |  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Prince Georges Beltsville   |  |         |  |   |  |                                    |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 12913 Forest View Drive              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |         |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |                                    |  |  |  |   |  |                                      |  |
| Eric Forster   |  |         |  |   | Lisles Goldberg                            |                                    |  |  |  |   |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |         |  |   | 16b. SOCIAL SECURITY NO.                   |                                    |  |  |  | 17. INFORMANT ADDRESS   |  |                                      |  |
| No   |  |         |  |   | 468-34-8449                                |                                    |  |  |  | David Kremnitzer, 12913 Forest View Dr. Beltsville, Md.   |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |         |  |   |  |                                    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |                                    |  |  |  |   |  |                                      |  |
| None   |  |         |  |   |  |                                    |  |  |  |   |  |                                      |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                    |  |  |  | 20. AUTOPSY?  |  |                                      |  |
| 1/3/79   |  |         |  | Hip replacement surgery for arthritis.  |  |                                    |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |                                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                                      |  |
|  |  |         |  | P.M. 19   |  |                                    |  | None   |  |   |  |                                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                      |  |
|  |  |         |  |   |  |                                    |  |  |  |   |  |                                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |   |  |                                    |  |  |  |   |  |                                      |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                                    |  | DATE SIGNED  |  |   |  |                                      |  |
| John S. Rogers, M.D.   |  |         |  | Deputy  |  |                                    |  | 2/5/79   |  |   |  |                                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                                    |  |  |  |   |  |                                      |  |
| John S. Rogers, M.D.   |  |         |  | 1919 Seminary Road Silver Spring, Montgomery, Md.   |  |                                    |  |  |  |   |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                      |  |
| Burial   |  |         |  | 2-6-79  |  | Judean Memorial Gdn.               |  |  |  | Olney, Montgomery, Maryland   |  |                                      |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  | ADDRESS   |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |
| Danzansky-Goldberg Mem. Chap. Rockville, Md.   |  |         |  | 1170 Rockville Pike   |  |                                    |  | FEB 8 1979   |  | Anthony M. Brady  |  |                                      |  |

79-04715



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |              |  |                                  |   |                                 | REG. NO. 79-04713 |
|--|--|--|--|--|--------------|--|----------------------------------|---|---------------------------------|-------------------|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST<br>FRANCES   | MIDDLE<br>L. | LAST<br>LARSEN   | 2a. DATE OF DEATH MONTH DAY YEAR |   | 2b. HOUR                        |                   |
|  |  | 3. SEX   |  | F  | 4. RACE      |  | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY) |                   |
|  |  |  |  | W  | 11-21-07     |  | 71 YRS.                          |   | 02-6-79 8:30 PM                 |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                  |   |                                 |                   |
| Kansas   |  | USA  |  |  |              | Montgomery MD.   |                                  |   |                                 |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |              | 12b. KIND OF BUSINESS OR INDUSTRY  |                                  |   |                                 |                   |
| Takoma Park  |  | Washington Adventist Hospital  |  | Housewife  |              | own home   |                                  |   |                                 |                   |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |              | 13d. INSIDE CITY LIMITS?   |                                  | 13e. STREET ADDRESS   |                                 |                   |
| Maryland   |  | Montgomery   |  | Sil. Spring  |              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                                  | 2110 Dexter Avenue,   |                                 |                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |              | 16b. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS   |                                 |                   |
| John C. Frank  |  | Minnie M. Moore  |  | no   |              | 515-22-0482  |                                  | A Ruth L. Atkinson-sister-(same as 13)                              |                                 |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |              | DUE TO, OR AS A CONSEQUENCE OF (c)   |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                                 |                   |
| 7999   |  | RESPIRATORY ARREST   |  | POSSIBLE RECURRENT PNEUMONIA VS. SEPSIS  |              |  |                                  |   |                                 |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |              | 20a. AUTOPSY?  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                 |                   |
| INAPPROPRIATE ADP, ANEMIA, SPARK IN SCALP, PROGRESSIVE SENILE DEMENTIA, FLUO   |  |  |  |  |              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                 |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |              | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                 |                   |
|  |  | P.M. 19  |  |  |              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                  |   |                                 |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 6 NOV 1978 to 6 FEB 1979, that (I) (we) last saw the deceased alive on 6 FEB 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |              | 22c. DATE SIGNED   |                                  |   |                                 |                   |
|  |  | W. Gerling MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |              | 6 Feb 79   |                                  |   |                                 |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR  |              | 22g. REGISTRAR'S SIGNATURE   |                                  |   |                                 |                   |
| WILLIAM GERLING  |  | 7600 CARROLL AVE - FHC   |  | FEB 13 1979  |              | M. J. McCready   |                                  |   |                                 |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |              | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                                  |   |                                 |                   |
| Burial   |  | 2-10-79  |  | Memorial Pk. Cemetery  |              | Topeka Shawnee Kansas  |                                  |   |                                 |                   |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |              | 25c. DATE REC'D. BY REGISTRAR  |                                  |   |                                 |                   |
| Warner E. Pumphrey, Inc.   |  | FEB 13 1979  |  | M. J. McCready   |              |  |                                  |   |                                 |                   |
| 8434 Ga. Ave., S.S. Md.  |  |  |  |  |              |  |                                  |   |                                 |                   |

4000  
BP



78-04113

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

RECEIVED  
FBI

Washington, D.C.  
20535  
U.S. Department of Justice  
Federal Bureau of Investigation  
Room 5636  
400 ...  
Washington, D.C. 20535

John ...  
Frank ...  
215-52-6824-R  
Room 5636  
Washington, D.C. 20535

END

10/10/78

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-78 BY SP-10 JLM/STP  
FBI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 79-04714  |  |  |                                    |   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------------|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2-22-79   |  | 2b. HOUR 9:30 P.M.   |                                    |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE MARCELE LEATHERMAN  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS 1 1   | 8. IF UNDER 74 HRS. HOURS MIN. 1 1 |   |  |
| 3. SEX F   |  | 4. RACE CAUC   |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 22 12   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.                      |  |  |  |  |                                    |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                  |  | 10. CITY OR TOWN OF DEATH BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER |  | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME   |  |  |                                    |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 525 WOODSTON RD.   |  |  |  |  |  |  |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST ESTON - DOLLY                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - WEIMER                         |                                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO. NONE                        |  | 17. INFORMANT 525 WOODSTON RD. BRADY STONE STREET, ROCKVILLE MD                                  |  |  |  |  |  |  |  |  |                                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) INTRA CEREBRAL HEMORRHAGE<br>400- DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE 10 YRS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS                                |  |  |                                    |   |  |
| 20. DATE OF OPERATION -  |  |  |  |  |  |  |  |  |  | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED -                                  |  | 22. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    | 23. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) COLLAPSED AT HOME |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 525 WOODSTON RD. ROCKVILLE MONT. MD |  |  |                                    |   |  |
| 22a. I certify that (I) (this person) attended the deceased from 2-22-1979 to 2-22-1979, that (I) (we) last saw the deceased alive on 2/22/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and not) view the body after death.  |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE F.C. MABLE  |  | 22c. DATE SIGNED 2-23-79   |                                    |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.C. MABLE   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 8200 WISCONSIN AVE BETHESDA MD 20814                                  |  |  |                                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 23b. DATE 2-26-79                                    |  | 23c. NAME OF CEMETERY OR CREMATORY GLENDALE CEM.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE FLINTSTONE ALLEG. MD   |  | 24. DATE REC'D. BY REGISTRAR FEB 28 1979                                 |  | 25. REGISTRAR'S SIGNATURE [Signature]  |  |  |                                    |   |  |
| 26. FUNERAL DIRECTOR [Signature] 111s. Mineral Street Markwood Funeral Home, Keyser, W. Va.  |  |  |  |  |  |  |  |  |  |  |  |  |                                    |   |  |

10-01114



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 79-04715   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| ISIDOR LEENOV  |  |  |  |  |  |  |  |  |  | February 21 1979   |  |  |  |  |  |  |  |  |  | 11:29AM  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YEAR  |  |  |  |  |  |  |  |  |  | 8. IF UNDER 24 HRS |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| MALE   |  |  |  |  |  |  |  |  |  | WHITE  |  |  |  |  |  |  |  |  |  | AUGUST 17, 1893  |  |  |  |  |  |  |  |  |  | 85 YRS.   |  |  |  |  |  |  |  |  |  | MONTHS              |  |  |  |  |  |  |  |  |  | DAYS               |  |  |  |  |  |  |  |  |  | HOURS |  |  |  |  |  |  |  |  |  | MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |  |  |  |  | MD.                 |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| RUSSIA   |  |  |  |  |  |  |  |  |  | U S A  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | MONTGOMERY  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| OLNEY  |  |  |  |  |  |  |  |  |  | MONTGOMERY GENERAL HOSPITAL  |  |  |  |  |  |  |  |  |  | U S GOV'T.   |  |  |  |  |  |  |  |  |  | RETIRED   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| MARYLAND   |  |  |  |  |  |  |  |  |  | MONTGOMERY   |  |  |  |  |  |  |  |  |  | SILVER SPRING  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 8484 16th STREET    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| FIVE   |  |  |  |  |  |  |  |  |  | LEENOV   |  |  |  |  |  |  |  |  |  | UNKNOWN  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| NO   |  |  |  |  |  |  |  |  |  | 092-16-9224  |  |  |  |  |  |  |  |  |  | ESTHER FERGUSON  |  |  |  |  |  |  |  |  |  | 1406 East West Highway, Hyattsville, Md. 20783                      |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 410 -  |  |  |  |  |  |  |  |  |  | Acute Myocardial Infarction  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 3 HRS   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  | Arteriosclerotic Cardiovascular disease  |  |  |  |  |  |  |  |  |  | 4 YRS.  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  | Organic Brain Syndrome   |  |  |  |  |  |  |  |  |  | 2 YRS   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | P.M.   |  |  |  |  |  |  |  |  |  | 19   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY   |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  |  |  |  |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  |  |  |  |  |  | STREET   |  |  |  |  |  |  |  |  |  | CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 2/4/79   |  |  |  |  |  |  |  |  |  | Lawrence Thomas M.D.   |  |  |  |  |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  |  |  |  |  |  |  | 2/22/79   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Lawrence Thomas, M. D.   |  |  |  |  |  |  |  |  |  | 11801 Rockville Pike, Rockville, Maryland  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| BURIAL   |  |  |  |  |  |  |  |  |  | 2/25/1979  |  |  |  |  |  |  |  |  |  | B'NAI ISRAEL CONG.   |  |  |  |  |  |  |  |  |  | OXON HILL P. G. MARYLAND  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| D.M. STEIN HEBREW MEMORIAL F.H.  |  |  |  |  |  |  |  |  |  | FEB 20 1979  |  |  |  |  |  |  |  |  |  | Hofsky, H. Brady   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 232 CARROLL ST., N.W., WASH. D. C.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |

21540-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 79-04716  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MARY MIDDLE Henderson LAST Lehr  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2/25/79                                       |  |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 14 92                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.  |  |
| 10. CITY OR TOWN OF DEATH Gaithersburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.                            |  |
| 13a. STATE MD   |  | 13b. COUNTY Baltimore  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W Henderson  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary V. Arthur  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. 220-543051  |  | 17. INFORMANT ADDRESS Asbury Medical Records                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4340 Terminal cerebral thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ————<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ————  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30m |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 2/25/79, 19, that (I) (we) last saw the deceased alive on 2/23/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE MD  |  | 22c. DATE SIGNED 2/25/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSO TH LEXABU MD  |  | 22e. ADDRESS 7425 arlington lee Baltimore Md   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 2/28/79  |  | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery                           |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md.   |  | 23e. DATE REC'D. BY REGISTRAR MAR 5 1979   |  | 23f. REGISTRAR'S SIGNATURE History McNeely                                     |  |
| 24. FUNERAL DIRECTOR Gartner-Sandison F. H.   |  | 316 E. Diamond Ave. Gaithersburg, Md.  |  |  |  |

19-0416

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

[Illegible body text]

DATE: 10/10/64  
BY: [Illegible]  
[Illegible]  
[Illegible]



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

20% OCT 1964



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |   |                             |   |  |  |  | REG. NO. 79-04717   |  |                               |
|--|------------------|--|--|---|-----------------------------|---|--|--|--|---|--|-------------------------------|
| 1- STATE REGISTRAR   |                  |  |  |   |                             |   |  |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                      |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Elsa Paula Leon  |                  |  |  |   |                             |   |  |  |  | 2. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br>2 27 19 79                       |  | 2b. HOUR<br>8:10A             |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 20 19 39  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS. | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>2 27 19 79                       |  |  |  |   |  |                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Cuba  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.              |  |  |  |   |  |                               |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Beautician |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cosmetology |  |   |  |                               |
| 13a. STATE<br>Md.  |                  |  |  |   |                             |   |  |  |  | 13b. COUNTY<br>Montg.   |  | 13c. CITY OR TOWN<br>Bethesda |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Gregorio Gonez  |                  |  |  |   |                             |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pura Gomez                            |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO   |                  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>105-34-1857  |  | 17. INFORMANT ADDRESS<br>Medardo Leon, Jr. same as 13e  |                             |   |  |  |  |   |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of Head</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |                             |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                               |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                             |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                               |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>8 xx 2 27 19 79  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot   |                             |   |  |  |  |   |  |                               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>4415 Chestnut St. Bethesda Mont. MD   |                             |   |  |  |  |   |  |                               |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from _____<br>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |   |                             |   |  |  |  | TITLE (SPECIFY)<br>Deputy Chief   |  |                               |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |                  | M.D. Deputy Chief  |  | FICIAL EXAMINER   |                             | DATE SIGNED<br>2/28/79  |  |  |  |   |  |                               |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |                  | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |                             |   |  |  |  |   |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>3/2/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Silver Spring, Md.               |  |  |  |   |  |                               |
| 24. FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey  |                  | Bethesda, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979   |                             | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreary                              |  |  |  |   |  |                               |

10-04513

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (1))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04718

|  |   |  |   |   |                  |   |  |
|--|---|--|---|---|------------------|---|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH  |   | XX MONTH DAY YEAR   |                  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | FIRST  |   | MIDDLE  |                  | LAST  |  |
| Medardo  |   | Leon   |   |   |                  |   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  | 2d. HOUR                                     |
| Male   | White   | Jul. 18, 1928  | 50 YRS.   |   |                  | 2 27 19 79  | 8:17   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED   | XXX NEVER MARRIED   | WIDOWED   | DIVORCED         | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Cuba   | U.S.A.  |  |   |   |                  | Montgomery County, MD.  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)      |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                  |   |  |
| Bethesda   | Suburban Hospital   | Mail clerk   |   | U.S. Govt.  |                  |   |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                  |   |  |
| MD.  | Montg.  | Bethesda   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4415 Chestnut St.   |                  |   |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS   |  |
| unknown  | Leon  | NO   |   | 267-66-0305   |                  | Medardo Leon, Jr. same as 13e                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:   |   |  |   |   |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Gunshot wounds of chest</u>   |   |  |   |   |                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |   |   |                  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last.</u>   |   |  |   |   |                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |   |   |                  |   |  |
| (c)  |   |  |   |   |                  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |   |  |   |   |                  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                  |   |   |                  | 20. AUTOPSY?  |  |
|  |   |  |   |   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                  |   |  |
|  |   | 8 xx. 2 27 19 79   |   | self inflicted  |                  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)        |   | 21f. LOCATION   |                  |   |  |
|  |   | house  |   | 4415 Chestnut St. Bethesda Mont. MD   |                  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |   |  |   |   |                  |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)  |   |   |                  | DATE SIGNED   |  |
| <i>Thomas D. Smith</i>   |   | M.D. Deputy Chief  |   |   |                  | 2/28/79   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS  |   |   |                  |   |  |
| Thomas D. Smith, M.D.  |   | 111 Penn St. Balto., MD.   |   |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                  | 23d. LOCATION   |  |
| Burial   |   | 3/2/79   |   | Gate of Heaven  |                  | Silver Spring, MD.  |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR                                      |   | 25b. REGISTRAR'S SIGNATURE  |                  |   |  |
| Robert A. Pumphrey   |   | MAR 5 1979   |   | <i>Robert A. Pumphrey</i>   |                  |   |  |

81710-07

Released by Dr. Sale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04719

REG. NO.

|   |   |   |  |  |                                   |  |  |
|---|---|---|--|--|-----------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH   |  | MONTH  | DAY                               | YEAR   | 2b. HOUR   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE   | LAST   |                                   | 2b. HOUR   |  |
| Everett   |   | BURTON  | Leser  |  | 2-15-79                           |  | 7:00 P.M.  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | 7. IF UNDER 1 YEAR   |  |
| MALE  | WHITE   | OCT 26, 1924  |  | 54 YRS   |                                   | MONTHS OATS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   | 10. IF UNDER 24 HRS  |  |
| PENNSYLVANIA  | U.S.A.  |   |  | Montgomery   |                                   | MD.  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Bethesda  | Suburban Hospital   |   | SALESMAN   |  | TRUCK CO.                         |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS  |                                   |  |  |
| MARYLAND  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 4416 MAHAN ROAD  |                                   |  |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |  |  |                                   |  |  |
| FRANK   |   | HELEN   |  | ELIZABETH HALL   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |                                   |  |  |
| YES   |   | 219-12-4565   |  | GERALDING NORMA LESER SAME AS 13 WIFE  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <del>arteriosclerotic heart disease</del><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hours<br>12 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 Feb 1979, to 15 Feb 1979, that (I) (we) last saw the deceased alive on 15 Feb 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br>Paul J. Young MD  |   | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |  |                                   |  |  |
| PAUL YOUNG  |   | BETHESDA, MARYLAND  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| BURIAL  |   | 2/20/79   |  | FORT LINCOLN   |                                   | BRENTWOOD PRI GEO MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   | 25a. DATE REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| FRANCIS J. COLLINS  |   | FEB 22 1979   |  | [Signature]  |                                   |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |   |   |  |  |                                   |  |  |

9-04719

EX-100

WHITE

WIFE

U.S.A.

PENNSYLVANIA

SALISBURY

1118 MAIN ROAD

MONTGOMERY SILVER SPRING

MARYLAND

FRANK

GEORGE

LESTER ST.

HELEN

ELIZABETH

WILL

WIFE

219-12-4588

GEORGETOWN MARYLAND

STATE AS 13

PAUL YOUNG

DETIAL

2/19/77

FORT LINDSEY

BREITWOOD

FRI GEO

500 EIGHTH BLVD. W. SILVER SPRING, MD. 20901

FRANCIS J. COLLINS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page-3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

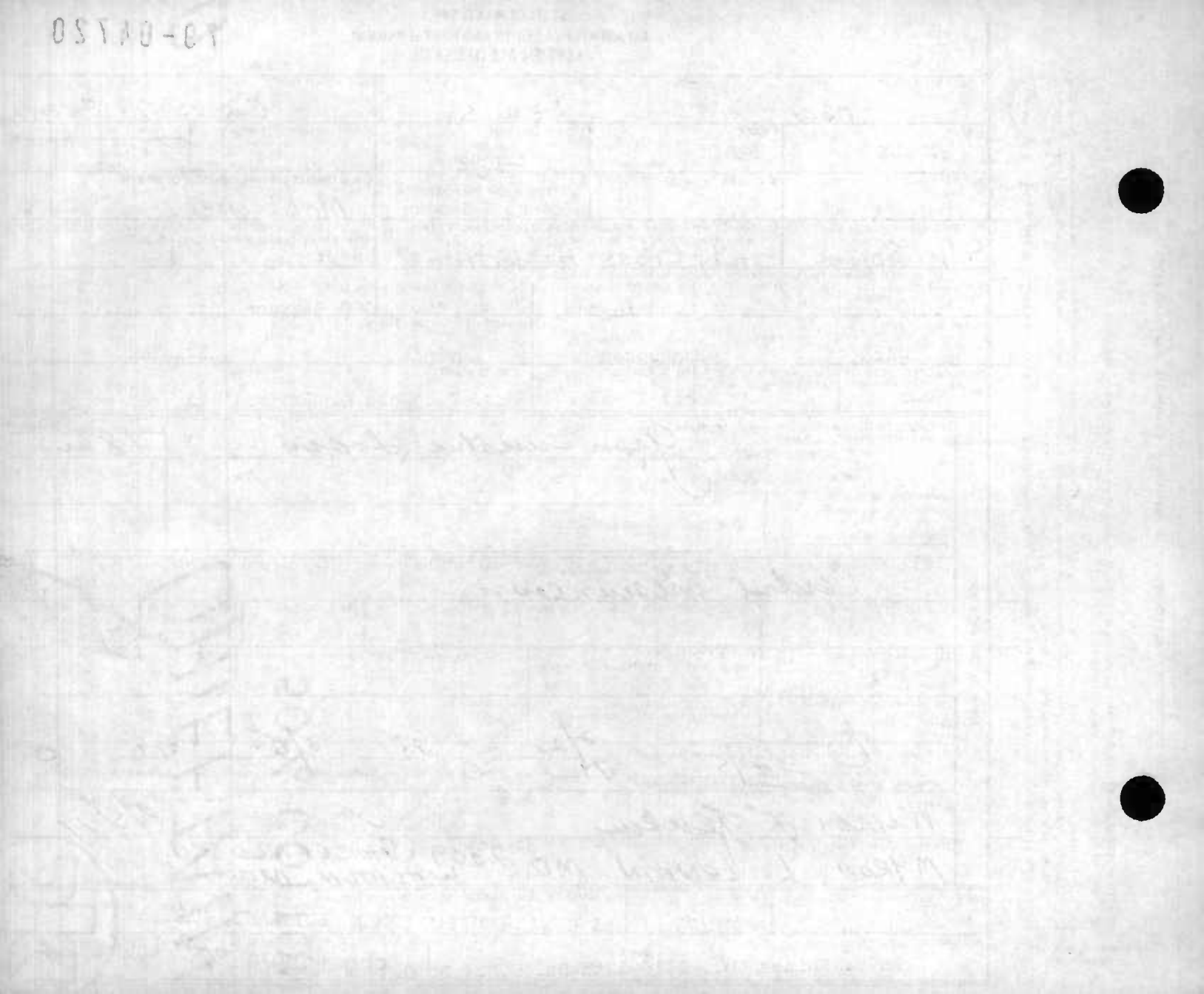
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | 79-04720  |  |   |   |  |  |
|--|--|--|--|---|---|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.  |  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rose</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>02-05-79</b>                                  |  |   |   |  |  |
| 3. SEX <b>FEMALE</b>   |  |  |  |   | 2b. HOUR <b>3:45 PM</b>   |  |   |   |  |  |
| 4. RACE <b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5-9-1892</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                     |   |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |  |
| 13a. STATE <b>D.C.</b>   |  | 13b. COUNTY <b>Washington</b>  |  | 13c. CITY OR TOWN <b>Washington</b>   |   | 13e. STREET ADDRESS <b>429 Emerson Street, N.W.</b>                            |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Edward Hansborough</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Luvania Triplett</b>             |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>None</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO. <b>579-22-5247</b>                                       |  | 17. INFORMANT ADDRESS <b>Mrs. Theodora L. Johnson/Daughter/same 13e</b> |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Gram negative Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>0384</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>48 hr.</b>                           |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral arteriosclerosis</b>   |  |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>2/28 1979</b>       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>79</b> , to <b>2/6</b> , 19 <b>79</b> , that (I) (we) saw the deceased alive on <b>2/5</b> , 19 <b>79</b> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE <b>Myron L. Lenkin</b>  |  |  |  |   | DEGREE  |  | 22c. DATE SIGNED <b>7/5/79</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN MD</b>  |  |  |  |   | 22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON, MD.</b>                               |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE <b>2/10/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEMORIAL CEMET</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>SUITLAND, MARYLAND</b>    |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>John T. Rhines Co., 3015 12th St., N.E., D.C.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE <b>Kathy McCreedy</b>                        |   |  |  |

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05740-07

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                                   | REG. NO. 79-04721                                     |  |
|--|--|--|--|---|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sandra Kay Lewis  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB 7 1979   |  |  | 2b. HOUR<br>9:57 P.M.             |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 21, 1943  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>35 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | IF UNDER 24 HRS<br>HOURS MIN                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8109 Whirl Wind Court |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |                                   |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Gaithersburg   |  | 13e. STREET ADDRESS<br>8109 Whirl Wind Court   |  |  |                                   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Brown  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mabel Walker  |  |  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-42-0224  |  | 17. INFORMANT<br>R. Bruce Lewis   |  | ADDRESS<br>8109 Whirl Wind Court<br>Gaithersburg, Md. 20760  |  |  |                                   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST<br>1749 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) METASTATIC CARCINOMA OF THE BREAST<br>(c) PRIMARY BREAST CARCINOMA<br>Dec 7 1978<br>July 1977   |  |  |  |   |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>December 1978</u> to <u>FEBRUARY 1979</u> , that (I) (we) last saw the deceased alive on <u>FEB 7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br>William D. Wehant M.D.   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>8 Feb 79      |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM D. WEHANT, MD   |  |  |  |   |  | 22e. ADDRESS<br>12904 CAMELIA DR, S.S. MD, 20906   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 11, 79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Frostburg Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frostburg, Allegany, Md.   |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi Funeral Home  |  |  |  | 11800 New Hampshire<br>Silver Spring, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Patsy McCreedy   |                                   |   |  |

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15540-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | 79-04722   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>MARTHA LOUISE LODER  |  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>1 20 79   |  | 2b. HOUR<br>2:40 A.M.  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 13 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 74 HRS.<br>HOURS MIN.                                 |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Denmark  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1948 Seminary Rd, S.S. |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Private                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |  |  |  |  |
| 13a STATE<br>Md  |  | 13b COUNTY<br>Montgomery  |  | 13c CITY OR TOWN<br>Silver Spring  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>1948-Seminary  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>NOT KNOWN   |  |   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NOT KNOWN  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None  |  | 17 INFORMANT<br>ADDRESS<br>C.G. Ashworth, 1948 Seminary Rd   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): congestive heart failure<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) arteriosclerotic heart disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs<br>3 yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75, to 1-20, 19 79, that (I) last saw the deceased alive on 1-17, 19 79, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>G. F. Senigstack M.D.  |  |   |  |  |  | DEGREE<br>MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-20-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Geo. F. Senigstack, M.D.  |  |   |  |  |  | 22e. ADDRESS<br>9241 Columbia Blvd S.S. Md 20910   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>1/22/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland P. Geo Md   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.W. Chambers  |  |   |  |  |  | ADDRESS<br>8655 Geo Ave, S.S.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>J. H. H. H. H.                   |  |

12-0155

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WATSON LANE COLOS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                   |  |  |   |  |  |  | 79-04723   |           |                     |  |
|---|--|--|-------------------|--|--|---|--|--|--|--|-----------|---------------------|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.          |  |  |   |  |  |  |  |           |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH |  |  | MONTH   |  | DAY  |  | YEAR   |           | 2b. HOUR            |  |
| EILEEN ELIZABETH LOVEJOY  |  |  | FEBRUARY 21, 1979 |  |  |   |  |  |  |  | 3:30 P.M. |                     |  |
| 3. SEX  |  | 4. RACE  |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |           |                     |  |
| FEMALE  |  | WHITE  |                   | NOV 12, 1934   |  | 44 YRS.   |  | MONTHS   |  | DAYS   |           | HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |           |                     |  |
| WASHINGTON, D.C.  |  | U.S.A.   |                   |  |  | MONTGOMERY MD.  |  |  |  |  |           |                     |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |           |                     |  |
| WHEATON   |  | 11920 ANDREW COURT   |                   |  |  | HOUSEWIFE   |  |  |  |  |           |                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |                   |  |  |   |  |  |  | 13d. INSIDE CITY LIMITS?   |           | 13e. STREET ADDRESS |  |
| 13a. STATE  |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 11920 ANDREW COURT   |  |  |           |                     |  |
| 14. FATHER'S NAME   |  |  |                   | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |           |                     |  |
| FIRST MIDDLE LAST<br>MICHAEL F. KILBRIDGE   |  |  |                   | FIRST MIDDLE LAST<br>MARY O'DONNELL  |  |   |  |  |  |  |           |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT  |  |   |  | ADDRESS  |  |  |           |                     |  |
| NO  |  | 579-48-2269  |                   | CHALMERS A. LOVEJOY  |  |   |  | SAME AS 13 HUSBAND   |  |  |           |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO OR AS A CONSEQUENCE OF (b) <u>Widespread metastases</u><br>DUE TO OR AS A CONSEQUENCE OF (c) <u>Malignant melanoma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <u>Coma &amp; electrolyte imbalance</u> |  |  |                   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 minutes</u><br><u>Months</u><br><u>1 1/2 yrs</u> |           |                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |           |                     |  |
|   |  |  |                   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |           |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |           |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |           |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 70</u> to <u>Feb 71</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Feb 21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                   |  |  |   |  |  |  |  |           |                     |  |
| 22b. SIGNATURE<br><u>Richard P. Delaney</u>   |  |  |                   |  |  | DEGREE  |  | 22c. DATE SIGNED<br>2.21.79                                    |  |  |           |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard P. Delaney, M.D.   |  |  |                   |  |  | 22e. ADDRESS<br>4323 Havard Street<br>Silver Spring, Md. 20906      |  |  |  |  |           |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |  |           |                     |  |
| BURIAL  |  | 2/24/79  |                   | GATE OF HEAVEN   |  | SILVER SPRING MONT MD.  |  |  |  |  |           |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME FRANCIS J. COLLINS ADDRESS   |  |  |                   |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |           |                     |  |
| 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901   |  |  |                   |  |  | FEB 22 1979   |  |  |  |  |           |                     |  |

BP

Richard P. Delaney, N.D.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                        |  |   |  |   |  |   |                                 | 79-04724<br>REG. NO.   |  |  |  |
|---|--|------------------------|--|---|--|---|--|---|---------------------------------|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                        |  |   |  |   |  |   |                                 |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mabel Lynch</b>   |  |                        |  |   |  |   |  |   |                                 | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>Feb 3, 1979</b>        |  | 2b. HOUR<br>AM PM<br><b>A</b>                    |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 16, 1890</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>88 YRS.</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |                                 | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Feb - 3 1979</b>      |  | 2d. HOUR<br>AM PM<br><b>9:30</b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  |                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4400 East West Highway</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |
| 13a. STATE<br><b>Md.</b>  |  |                        |  | 13b. COUNTY<br><b>Montg.</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | 13e. STREET ADDRESS<br><b>4400 East West Highway</b>                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nicholas Keimig</b>  |  |                        |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Adele Fox</b>                               |  |   |                                 |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |                        |  | 16b. SOCIAL SECURITY NO.<br><b>056-07-3759</b>  |  | 17. INFORMANT<br><b>Hugh Lynch, Jr.</b> ADDRESS<br><b>5200 Edgemoor Lane Bethesda, Md.</b>      |  |   |                                 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease -</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |                        |  |   |  |   |  |   |                                 |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                        |  |   |  |   |  |   |                                 |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |                                 | 20. AUTOPSY?<br>YES NO <input checked="" type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                   |  |   |                                 |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                 |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                        |  |   |  |   |  |   |                                 |  |  |  |  |
| ACTUAL SIGNATURE <b>John W. Ball</b> M.D.   |  |                        |  |   |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   | DATE SIGNED <b>Feb. 3, 1979</b> |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>   |  |                        |  |   |  | ADDRESS <b>7936 Old Georgetown Rd. Bethesda, Md.</b>  |  |   |                                 |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                        |  | 23b. DATE<br><b>Feb. 6, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cato of Heaven</b>                                     |  |   |                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Humphrey</b> ADDRESS <b>Homes, P.A. Bethesda, Md.</b>   |  |                        |  |   |  | 25a. DATE RECORDED BY REGISTRAR <b>FEB 7 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |   |                                 |  |  |  |  |

79-04724

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text block containing several lines of information, possibly a report or letterhead, with some words like "New York" and "Bureau" visible.]

[Large block of illegible text, likely the main body of a document or a series of notes. Some words like "New York", "Bureau", and "Subject" are faintly visible.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04725

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |   |   |  |  |  |
|--|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Russell MacArthur</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 17, 1979</b>                   |   |  | 2b. HOUR<br><b>4:30 AM</b>  |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 16, 1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.</b> MD.                           |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Damascus</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>26401 Cornor Dr.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Heating Engineer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Damascus</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>26401 Cornor Dr.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Duncan MacArthur</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Hipelius</b>         |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>040-20-1539</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Lorraine M. Monnier, Item 13</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4392</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b> |  |  |   |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (the doctor) attended the deceased from <b>12/18/78</b> , 19 <b>78</b> , to <b>2/17</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |  |   |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>James P. Kerr, M.D.</b>   |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>2/17/79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James P. Kerr, M.D.</b>  |  |  |   |   | 22e. ADDRESS<br><b>26618 Ridge Rd., Damascus, Md.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Feb. 20, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>East Lawn</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>East Haven, Conn.</b>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Molesworth, Damascus, Md.</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCurdy</b>   |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

53-04752

194 1950-1951 1952-1953

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1998

REV. 05-80

5. *Conclusion*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the legal director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one of the following: 1. MURDER 2. SUICIDE 3. ACCIDENT 4. OTHER TRAUMATIC EVENT

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO. 79-04726   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | I. DECEASED NAME<br>(TYPE OR PRINT) <b>Luis</b> <b>Machado</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>Feb.</b> DAY <b>5</b> YEAR <b>1979</b>                           |  | 2b. HOUR<br><b>8:17 P.M.</b>   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>25</b> YEAR <b>1899</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Cuba</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Cuba</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lawyer &amp; Banker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Inter. Finance Corp.</b>   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Md.</b> COUNTY <b>Montgomery</b> CITY OR TOWN <b>Bethesda</b>  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS<br><b>6832 Tulip Hill Terrace</b>   |  |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Luis</b> MIDDLE LAST <b>Machado</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Maria</b> MIDDLE LAST <b>Ortega</b>  |  |   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-68-1105</b>  |  | 17 INFORMANT <b>Brother</b> ADDRESS <b>Silver Spring, Md.</b><br><b>Roberto Machado. 14623 Tynewick Terr.</b>   |  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>410- Myocardial Infarction.</b><br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic H. Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>12 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 to <b>Jan 20</b> , 19 <b>79</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Jan 20</b> , 19 <b>79</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Bernard E. Nunez M.D.</b>  |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>Feb. 6, 1979</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard E. Nunez M. D.</b>  |  |   |  | 22e. ADDRESS<br><b>1780 - MASS AVE. N.W. D.C.</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/8/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Silver Spring, Maryland.</b> COUNTY STATE                     |  |  |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>JOSEPH GAWLER'S SONS INC.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |

MEDICAL CERTIFICATION

5800 BP

101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 79-04727                                     |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OLIVE D. MACKENZIE</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>8</b> YEAR <b>79</b>  |   |  | 2b. HOUR<br><b>11:55 P</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>August</b> DAY <b>29</b> YEAR <b>1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                       |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                     |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS<br><b>14635 Bauer Drive</b>                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b></b> LAST <b>Duggan</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Hannah</b> MIDDLE <b></b> LAST <b>Price</b>   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>124-20-4167</b>   |  | 17. INFORMANT<br>ADDRESS <b>Potomac, Maryland</b><br><b>Olive M. English 12705 Hunting Horn Court</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC ORGANIC BRAIN SYNDROME</b><br><b>4409</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DOE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DOE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET <b>78</b> CITY OR TOWN <b>218</b> COUNTY <b>79</b> STATE <b></b>   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/11/2</b> 19 <b>78</b> , to <b>2/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/11</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R. C. Daddario M.D.</b>   |  |   |  |   | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>2/8/79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT C. DADDARIO</b>   |  |   |  |   | 22e. ADDRESS<br><b>5413 CEDAR LAWE BETHESDA MD.</b>  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>2/9/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Alexandria</b> COUNTY <b>Virginia</b> STATE <b></b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Homes, P.A. Rockville, Maryland</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |  |



78-04757

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                                   |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |  |  |  |  | REG. NO. 79-04728                |  |
|--|--|-----------------------------------|--|---|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Francis M Maguire</b>   |  |                                   |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>Feb 17 1979</b>                            |  |   |  |   |  |  |  |  |  | 2b. HOUR OF DEATH <b>3:40 PM</b> |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 13 24 54</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>54</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD <b>Feb 17 1979</b>               |  | 7d. HOUR OF DEATH <b>3:40 PM</b>  |  |  |  |  |  |                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS.</b>   |  |                                   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b> |  |   |  |  |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>   |  |                                   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BLACKSMITH</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RACE TRACK</b>       |  |   |  |  |  |  |  |                                  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                   |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>Prince Georges</b> |  | 13c. CITY OR TOWN <b>Laurel</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>4436 Brookridge Rd.</b>  |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>FRANCIS X. MAGUIRE</b>   |  |                                   |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>ALEDA CHAMBERLIN</b>              |  |   |  |   |  |  |  |  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>   |  |                                   |  | 16b. SOCIAL SECURITY NO. <b>WW 2</b>  |  | 17. INFORMANT <b>PRISCILLA MAGUIRE</b>   |  |   |  | ADDRESS <b>SAME AS ABOVE</b>   |  |   |  |   |  |  |  |  |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>436-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                                   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-24 HRS</b>                      |  |   |  |   |  |  |  |  |  |                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |                                   |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                   |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |  |                                   |  | TITLE (SPECIFY) <b>M.D.</b>   |  |  |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>Feb 17, 1979</b>                           |  |   |  |  |  |  |  |                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                                   |  | ADDRESS   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                                   |  | 23b. DATE <b>Feb. 23, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans</b>                                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Cheltenham Md</b>                    |  |   |  |   |  |  |  |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Daniel Dean Funeral Home</b> ADDRESS <b>Laurel Md.</b>   |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |   |  |   |  |  |  |  |  |                                  |  |

18-0458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

DHMH - 16 50M 7/77  
(VR A 15 (4))

| FOR<br>1 - STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO.<br>79-04729  |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Roberta Lee Harker Malambre  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 22 79   |  | 2b. HOUR<br>9:30 AM   |   |
| 3. SEX<br>Female   | 4. RACE<br>White                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 1, 1885   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Asbury Village Gaithersburg, Md.               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Gaithersburg   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Harker   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary ONeal   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>?   |  | 17. INFORMANT<br>ADDRESS<br>Roberta Downes Laytonville Md.                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart failure<br>4140 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Heart Disease<br>(c) Intracerebral hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 days<br>yes<br>1 |
| MEDICAL CERTIFICATION  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Fall 1975 2/22 79, that (I) (we) lost<br>saw the deceased alive on 2/22 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |   |  |   |   |
| 22b. SIGNATURE<br>Thos G. Ward MD  |  |   |  | 22c. DATE SIGNED<br>2/22/79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thos G. WARD  |  |   |  | 22e. ADDRESS<br>6116 Belvedere Rd, Bethesda Md.   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2-24-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wards Chapel Cemetery                                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry W. Haight  |  | ADDRESS<br>Laytonville Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1979  |   |
| 25b. REGISTRAR'S SIGNATURE<br>Harry W. Haight  |  | 25c. REGISTRAR'S SIGNATURE<br>Harry W. Haight   |  |   |   |

50-0150

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04730

1 - FOR  
STATE  
REGISTRAR

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lewis F. Malcolm JR.</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 20 79</b>  |  | 2b. HOUR<br><b>6:06 P.M.</b>                              |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 27 19 64</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>64</b>                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silva Spring</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(RE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nuclear Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Atomic Energy</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Rockville</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>LEWIS F. MALCOLM</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ROSE CRONENBERGER</b>  |   | 13e. STREET ADDRESS<br><b>14607 Crossway Rd.</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>713-01-3770</b>  |   | 17. INFORMANT ADDRESS<br><b>EVANGELINE L. MALCOLM (SAME AS 13E)</b>                          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>431-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIO SCLEROTIC VASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>10 YEARS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b> |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>1. DIABETES MELLITUS 2. OBESITY</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>FEB 17, 1979</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CHOLECYSTITIS, CHOLELITHIASIS</b>  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)          |   |  |   |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/16/79</b> , 19 <b>79</b> , to <b>2/20</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Harold S. Tidler M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>2/21/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAROLD S. TIDLER, M.D.</b>   |   | 22e. ADDRESS<br><b>9801 GEORGIA AVE. SILVER SPRING, MD. 20902.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |   | 23b. DATE<br><b>2-23-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY ALEXANDRIA, FAIRFAX VA.</b>  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES P/A</b>   |   | ADDRESS<br><b>ROCKVILLE MD.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1979</b>  |   |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 79-04731   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arthur G. Malmon</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-3-79</b> 2b. HOUR <b>4:45 PM</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Oct 29, 1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Physicist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Research Consult.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13e. STREET ADDRESS<br><b>9802 Ashburton Lane</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frieda Gollin</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>394-24-3583</b>   |  | 17. INFORMANT<br>ADDRESS <b>Glencoe, Illinois</b><br><b>Howard Schwarzbach; 718 Sheridan Road</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b><br><b>5698</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumothorax</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/27/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Pneumothorax</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27/79</b> , 19 <b>79</b> , to <b>2/3/79</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2/3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert H. Varney, MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/4/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert H. Varney, MD</b>   |  |   |  | 22e. ADDRESS<br><b>Suburban Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-9-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Milwaukee, Wisconsin</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1979</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 79-04732<br>REG. NO.  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SARA - MARKISON</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 9, 1979</b>  |   |  | 2b. HOUR<br><b>535 P.M.</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 20, 1890</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY CO. MD.</b>                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Nursing Home &amp; Retirement Housewife</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |   |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1111 University Blvd., West.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mordecai Gladstein</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary (Unknown)</b>                                |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>176-28-7381D</b>                        |   | 17. INFORMANT<br>ADDRESS<br><b>Charles Markison Kensington, Maryland</b><br><b>9520 Barroll Lane,</b> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT ("Stroke")</b>   |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 days</b> |
| 402-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive ArterioSclerotic Heart Disease</b>   |  |  |  |   |   |   |  |  | over 20 yrs  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (we) (hospital) attended the deceased from <b>19 55</b> to <b>Feb 9th</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Feb 6th</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Samuel Dove</b>   |  |  |  |   | DEGREE<br><b>M.D.</b>   |   |  | 22c. DATE SIGNED<br><b>9 February 79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL DOVE, M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>818-18th Street, N.W., #240 - Washington, D.C., 20006</b>                          |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>2/11/1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEM. GARDEN</b>                                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FALLS CHURCH VIRGINIA</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>D. M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>  |  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1979</b>  |   |  |  |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D.C.   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE  |   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 47 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 79-04733   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kehl</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>Feb. 28, 1979</b>   |  |
| 3. SEX <b>Cauc.</b> 4. RACE <b>Male</b> 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Sept. 11 1923</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.   |  |  |  |  |  |  |  |  |  | 7b. HOUR <b>2:10 P.M.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>Feb. 28, 1979</b> 2d. HOUR <b>2:20 P.M.</b>                           |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.   |  |  |  |  |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physician</b>                    |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>Public Health</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 13e. STREET ADDRESS <b>6513 Callander Drive</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Kehl Markley Tl</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Lena Leh</b>                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>195 14 7694</b>   |  |
| 17. INFORMANT ADDRESS <b>Rick Markley See item 13</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4249</b> IMMEDIATE CAUSE (a) <b>Endocarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 weeks</b>                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                 |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                       |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b> TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>01 Mar. 1979</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b> ADDRESS <b>Bethesda, Md.</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Lee's Funeral Home Washington, D.C.</b>  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Robert McCready</b> |  |

10-0133

EVERY III

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201-04734  
CERTIFICATE OF DEATH

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Thomas F. Martin</i>   |   |   | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>21</i> Year <i>1979</i>                              |   | 2b. HOUR<br><i>11:30</i> A.M.  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH<br><b>JULY 8, 1928</b>   |   | 6. AGE (In years last birthday)<br><b>50</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS<br>HOURS<br>MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>INDIANA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WASHINGTON ADVENTIST HOSPITAL</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>RESTAURANT OWNER</b>               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>MONTGOMERY</b>  |   | 13b. CITY OR TOWN<br><b>SILVER SPRING</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>817 LOXFORD TERRACE</b>  |  |
| 14. FATHER'S NAME<br>First <b>HENRY</b> Middle <b>B.</b> Last <b>MARTIN</b>   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>BEULAH</b> Middle <b>R.</b> Last <b>RAYLE</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>YES</b> (If yes give actual dates of service) <b>KOREA</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>310-24-6434</b>  |   | 17. INFORMANT<br>Name <b>BERNICE M. MARTIN</b> Address <b>SAME AS 13 WIFE</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1509 Sudden</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial Infarction of Ischemic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Coronary atherosclerosis</b><br>(b) <b>Myocardial Infarction of Ischemic</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Coronary atherosclerosis</b><br>(c) <b>Coronary atherosclerosis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 2-20</b> , 19 <b>79</b> , to <b>2-20-79</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2-20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Donald C. Edgren M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DONALD C. EDGREN M.D.</b>  |   | 22c. DATE SIGNED<br><b>2-21-79</b>  |   |   |  |
| 22e. ADDRESS<br><b>6201 Greenbelt Rd<br/>College Park</b>   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>2/24/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>   |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>SILVER SPRING MONT MD.</b>  |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS J. COLLINS</b>   |   | ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |   | 25. REC'D BY REGISTRAR<br><b>FEB 22 1979</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04735

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William E. May</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 17, 1979</b>                    |   | 2b. HOUR<br><b>6:00am</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 8, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b><br>YRS MONTHS DAYS HRS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Analyst</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>   |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Howard</b>   | 13c. CITY OR TOWN<br><b>21029</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward A. May</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Almira Starr</b>               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>W.W. II 135-01-9167</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>21029 Tabb Taylor May 6722 Hitching Post Ct.</b> |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Retropertitoneal Sarcoma, Extensive</b><br>1580<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months to Years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>John R. Minarcik</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John R. Minarcik, MD</b>   |   | 22e. ADDRESS<br><b>18101 Prince Philip Dr., Olney, Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>Feb. 19, '79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1979</b>  |  |   |  |
| 24. NAME OF FUNERAL DIRECTOR<br><b>William E. Johnson</b>  |   |   |  |   |  |

10-04132

January 17, 1972

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London General Hospital

New York

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |           |   |  |   |  |  |   |  |                           | REG. NO. 79-04736   |  |              |
|---|-----------|---|--|---|--|--|---|--|---------------------------|---|--|--------------|
| 1. FOR STATE REGISTRAR  |           | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John H McAuliffe   |  |   |  |  |   |  |                           | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> 2-22 1979 |  | 2b. HOUR A M |
| 3. SEX M  | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 5-27 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.                     | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN   | 2c. DATE PRONOUNCED DEAD Feb-22 1979                        |  | 2d. HOUR 8 A M            |   |  |              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California  |           | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.         |  |                           |   |  |              |
| 10. CITY OR TOWN OF DEATH Chevy Chase   |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4515 Willard Ave. Apt. 1009 South |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired                        |   | 12b. KIND OF BUSINESS OR INDUSTRY Army   |                           |   |  |              |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |           |   |  |   |  |  |   |  |                           |   |  |              |
| 13a. STATE Maryland   |           | 13b. COUNTY Montgomery  |  | 13c. CITY OR TOWN Chevy Chase                               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS 4515 Willard Ave. Apt. 1009 South                            |                           |   |  |              |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Mc Auliffe  |           |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Whitman    |  |  |   |  |                           |   |  |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes  |           | (IF YES, GIVE WAR OR DATES) WWII  |  | 16b. SOCIAL SECURITY NO. 567-50-8274                        |  | 17. INFORMANT ADDRESS Patricia A. Mc Auliffe 4515 Willard Ave. Chevy Chase, Md.              |   |  |                           |   |  |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |           |   |  |   |  |  |   |  |                           |   |  |              |
| PART I DEATH WAS CAUSED BY:   |           |   |  |   |  |  |   |  |                           |   |  |              |
| IMMEDIATE CAUSE (a) Cardiovascular Disease -  |           |   |  |   |  |  |   |  |                           |   |  |              |
| DUE TO, OR AS A CONSEQUENCE OF  |           |   |  |   |  |  |   |  |                           |   |  |              |
| (b) Carcinoma of Throat   |           |   |  |   |  |  |   |  |                           |   |  |              |
| DUE TO, OR AS A CONSEQUENCE OF  |           |   |  |   |  |  |   |  |                           |   |  |              |
| (c)   |           |   |  |   |  |  |   |  |                           |   |  |              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |           |   |  |   |  |  |   |  |                           |   |  |              |
| 19a. DATE OF OPERATION  |           |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |   |  |              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |           |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |   |  |                           |   |  |              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |           |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                           |   |  |              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |           |   |  |   |  |  |   |  |                           |   |  |              |
| ACTUAL SIGNATURE John G. Ball   |           |   |  | TITLE (SPECIFY) M.D. Deputy                                 |  | MEDICAL EXAMINER   |   |  | DATE SIGNED Feb. 22, 1979 |   |  |              |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL  |           |   |  | ADDRESS 7936 OLD GEORGETOWN RD. BETHESDA, MD.               |  |  |   |  |                           |   |  |              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |           | 23b. DATE Feb. 27, 79   |  | 23c. NAME OF CEMETERY OR CREMATORY Arlington National       |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia |  |                           |   |  |              |
| 24. BURIAL DIRECTOR NAME Hines/Rinaldi  |           | ADDRESS 11800 New Hampshire Ave. Sils Spg Md.   |  | 25a. DATE REC'D. BY REGISTRAR FEB 26 1979                   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |                           |   |  |              |

98-0138

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING"; IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04737  
REG. NO.

|                    |  |                                     |  |               |  |              |  |                |  |                         |  |                         |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                   |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    |  |                    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| 1- STATE REGISTRAR |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>John |  | MIDDLE<br>F. |  | LAST<br>McCabe |  | 2a. DATE KNOWN OF DEATH |  | 2b. DATE KNOWN OF DEATH |  | 2c. DATE OF DEATH |  | 2d. DATE OF DEATH |  | 2e. DATE OF DEATH |  | 2f. DATE OF DEATH |  | 2g. DATE OF DEATH |  | 2h. DATE OF DEATH |  | 2i. DATE OF DEATH |  | 2j. DATE OF DEATH |  | 2k. DATE OF DEATH |  | 2l. DATE OF DEATH |  | 2m. DATE OF DEATH |  | 2n. DATE OF DEATH |  | 2o. DATE OF DEATH |  | 2p. DATE OF DEATH |  | 2q. DATE OF DEATH |  | 2r. DATE OF DEATH |  | 2s. DATE OF DEATH |  | 2t. DATE OF DEATH |  | 2u. DATE OF DEATH |  | 2v. DATE OF DEATH |  | 2w. DATE OF DEATH |  | 2x. DATE OF DEATH |  | 2y. DATE OF DEATH |  | 2z. DATE OF DEATH |  | 2aa. DATE OF DEATH |  | 2ab. DATE OF DEATH |  | 2ac. DATE OF DEATH |  | 2ad. DATE OF DEATH |  | 2ae. DATE OF DEATH |  | 2af. DATE OF DEATH |  | 2ag. DATE OF DEATH |  | 2ah. DATE OF DEATH |  | 2ai. DATE OF DEATH |  | 2aj. DATE OF DEATH |  | 2ak. DATE OF DEATH |  | 2al. DATE OF DEATH |  | 2am. DATE OF DEATH |  | 2an. DATE OF DEATH |  | 2ao. DATE OF DEATH |  | 2ap. DATE OF DEATH |  | 2aq. DATE OF DEATH |  | 2ar. DATE OF DEATH |  | 2as. DATE OF DEATH |  | 2at. DATE OF DEATH |  | 2au. DATE OF DEATH |  | 2av. DATE OF DEATH |  | 2aw. DATE OF DEATH |  | 2ax. DATE OF DEATH |  | 2ay. DATE OF DEATH |  | 2az. DATE OF DEATH |  | 2ba. DATE OF DEATH |  | 2bb. DATE OF DEATH |  | 2bc. DATE OF DEATH |  | 2bd. DATE OF DEATH |  | 2be. DATE OF DEATH |  | 2bf. DATE OF DEATH |  | 2bg. DATE OF DEATH |  | 2bh. DATE OF DEATH |  | 2bi. DATE OF DEATH |  | 2bj. DATE OF DEATH |  | 2bk. DATE OF DEATH |  | 2bl. DATE OF DEATH |  | 2bm. DATE OF DEATH |  | 2bn. DATE OF DEATH |  | 2bo. DATE OF DEATH |  | 2bp. DATE OF DEATH |  | 2bq. DATE OF DEATH |  | 2br. DATE OF DEATH |  | 2bs. DATE OF DEATH |  | 2bt. DATE OF DEATH |  | 2bu. DATE OF DEATH |  | 2bv. DATE OF DEATH |  | 2bw. DATE OF DEATH |  | 2bx. DATE OF DEATH |  | 2by. DATE OF DEATH |  | 2bz. DATE OF DEATH |  | 2ca. DATE OF DEATH |  | 2cb. DATE OF DEATH |  | 2cc. DATE OF DEATH |  | 2cd. DATE OF DEATH |  | 2ce. DATE OF DEATH |  | 2cf. DATE OF DEATH |  | 2cg. DATE OF DEATH |  | 2ch. DATE OF DEATH |  | 2ci. DATE OF DEATH |  | 2cj. DATE OF DEATH |  | 2ck. DATE OF DEATH |  | 2cl. DATE OF DEATH |  | 2cm. DATE OF DEATH |  | 2cn. DATE OF DEATH |  | 2co. DATE OF DEATH |  | 2cp. DATE OF DEATH |  | 2cq. DATE OF DEATH |  | 2cr. DATE OF DEATH |  | 2cs. DATE OF DEATH |  | 2ct. DATE OF DEATH |  | 2cu. DATE OF DEATH |  | 2cv. DATE OF DEATH |  | 2cw. DATE OF DEATH |  | 2cx. DATE OF DEATH |  | 2cy. DATE OF DEATH |  | 2cz. DATE OF DEATH |  | 2da. DATE OF DEATH |  | 2db. DATE OF DEATH |  | 2dc. DATE OF DEATH |  | 2dd. DATE OF DEATH |  | 2de. DATE OF DEATH |  | 2df. DATE OF DEATH |  | 2dg. DATE OF DEATH |  | 2dh. DATE OF DEATH |  | 2di. DATE OF DEATH |  | 2dj. DATE OF DEATH |  | 2dk. DATE OF DEATH |  | 2dl. DATE OF DEATH |  | 2dm. DATE OF DEATH |  | 2dn. DATE OF DEATH |  | 2do. DATE OF DEATH |  | 2dp. DATE OF DEATH |  | 2dq. DATE OF DEATH |  | 2dr. DATE OF DEATH |  | 2ds. DATE OF DEATH |  | 2dt. DATE OF DEATH |  | 2du. DATE OF DEATH |  | 2dv. DATE OF DEATH |  | 2dw. DATE OF DEATH |  | 2dx. DATE OF DEATH |  | 2dy. DATE OF DEATH |  | 2dz. DATE OF DEATH |  | 2ea. DATE OF DEATH |  | 2eb. DATE OF DEATH |  | 2ec. DATE OF DEATH |  | 2ed. DATE OF DEATH |  | 2ee. DATE OF DEATH |  | 2ef. DATE OF DEATH |  | 2eg. DATE OF DEATH |  | 2eh. DATE OF DEATH |  | 2ei. DATE OF DEATH |  | 2ej. DATE OF DEATH |  | 2ek. DATE OF DEATH |  | 2el. DATE OF DEATH |  | 2em. DATE OF DEATH |  | 2en. DATE OF DEATH |  | 2eo. DATE OF DEATH |  | 2ep. DATE OF DEATH |  | 2eq. DATE OF DEATH |  | 2er. DATE OF DEATH |  | 2es. DATE OF DEATH |  | 2et. DATE OF DEATH |  | 2eu. DATE OF DEATH |  | 2ev. DATE OF DEATH |  | 2ew. DATE OF DEATH |  | 2ex. DATE OF DEATH |  | 2ey. DATE OF DEATH |  | 2ez. DATE OF DEATH |  | 2fa. DATE OF DEATH |  | 2fb. DATE OF DEATH |  | 2fc. DATE OF DEATH |  | 2fd. DATE OF DEATH |  | 2fe. DATE OF DEATH |  | 2ff. DATE OF DEATH |  | 2fg. DATE OF DEATH |  | 2fh. DATE OF DEATH |  | 2fi. DATE OF DEATH |  | 2fj. DATE OF DEATH |  | 2fk. DATE OF DEATH |  | 2fl. DATE OF DEATH |  | 2fm. DATE OF DEATH |  | 2fn. DATE OF DEATH |  | 2fo. DATE OF DEATH |  | 2fp. DATE OF DEATH |  | 2fq. DATE OF DEATH |  | 2fr. DATE OF DEATH |  | 2fs. DATE OF DEATH |  | 2ft. DATE OF DEATH |  | 2fu. DATE OF DEATH |  | 2fv. DATE OF DEATH |  | 2fw. DATE OF DEATH |  | 2fx. DATE OF DEATH |  | 2fy. DATE OF DEATH |  | 2fz. DATE OF DEATH |  | 2ga. DATE OF DEATH |  | 2gb. DATE OF DEATH |  | 2gc. DATE OF DEATH |  | 2gd. DATE OF DEATH |  | 2ge. DATE OF DEATH |  | 2gf. DATE OF DEATH |  | 2gg. DATE OF DEATH |  | 2gh. DATE OF DEATH |  | 2gi. DATE OF DEATH |  | 2gj. DATE OF DEATH |  | 2gk. DATE OF DEATH |  | 2gl. DATE OF DEATH |  | 2gm. DATE OF DEATH |  | 2gn. DATE OF DEATH |  | 2go. DATE OF DEATH |  | 2gp. DATE OF DEATH |  | 2gq. DATE OF DEATH |  | 2gr. DATE OF DEATH |  | 2gs. DATE OF DEATH |  | 2gt. DATE OF DEATH |  | 2gu. DATE OF DEATH |  | 2gv. DATE OF DEATH |  | 2gw. DATE OF DEATH |  | 2gx. DATE OF DEATH |  | 2gy. DATE OF DEATH |  | 2gz. DATE OF DEATH |  | 2ha. DATE OF DEATH |  | 2hb. DATE OF DEATH |  | 2hc. DATE OF DEATH |  | 2hd. DATE OF DEATH |  | 2he. DATE OF DEATH |  | 2hf. DATE OF DEATH |  | 2hg. DATE OF DEATH |  | 2hh. DATE OF DEATH |  | 2hi. DATE OF DEATH |  | 2hj. DATE OF DEATH |  | 2hk. DATE OF DEATH |  | 2hl. DATE OF DEATH |  | 2hm. DATE OF DEATH |  | 2hn. DATE OF DEATH |  | 2ho. DATE OF DEATH |  | 2hp. DATE OF DEATH |  | 2hq. DATE OF DEATH |  | 2hr. DATE OF DEATH |  | 2hs. DATE OF DEATH |  | 2ht. DATE OF DEATH |  | 2hu. DATE OF DEATH |  | 2hv. DATE OF DEATH |  | 2hw. DATE OF DEATH |  | 2hx. DATE OF DEATH |  | 2hy. DATE OF DEATH |  | 2hz. DATE OF DEATH |  | 2ia. DATE OF DEATH |  | 2ib. DATE OF DEATH |  | 2ic. DATE OF DEATH |  | 2id. DATE OF DEATH |  | 2ie. DATE OF DEATH |  | 2if. DATE OF DEATH |  | 2ig. DATE OF DEATH |  | 2ih. DATE OF DEATH |  | 2ii. DATE OF DEATH |  | 2ij. DATE OF DEATH |  | 2ik. DATE OF DEATH |  | 2il. DATE OF DEATH |  | 2im. DATE OF DEATH |  | 2in. DATE OF DEATH |  | 2io. DATE OF DEATH |  | 2ip. DATE OF DEATH |  | 2iq. DATE OF DEATH |  | 2ir. DATE OF DEATH |  | 2is. DATE OF DEATH |  | 2it. DATE OF DEATH |  | 2iu. DATE OF DEATH |  | 2iv. DATE OF DEATH |  | 2iw. DATE OF DEATH |  | 2ix. DATE OF DEATH |  | 2iy. DATE OF DEATH |  | 2iz. DATE OF DEATH |  | 2ja. DATE OF DEATH |  | 2jb. DATE OF DEATH |  | 2jc. DATE OF DEATH |  | 2jd. DATE OF DEATH |  | 2je. DATE OF DEATH |  | 2jf. DATE OF DEATH |  | 2jg. DATE OF DEATH |  | 2jh. DATE OF DEATH |  | 2ji. DATE OF DEATH |  | 2jj. DATE OF DEATH |  | 2jk. DATE OF DEATH |  | 2jl. DATE OF DEATH |  | 2jm. DATE OF DEATH |  | 2jn. DATE OF DEATH |  | 2jo. DATE OF DEATH |  | 2jp. DATE OF DEATH |  | 2jq. DATE OF DEATH |  | 2jr. DATE OF DEATH |  | 2js. DATE OF DEATH |  | 2jt. DATE OF DEATH |  | 2ju. DATE OF DEATH |  | 2jv. DATE OF DEATH |  | 2jw. DATE OF DEATH |  | 2jx. DATE OF DEATH |  | 2jy. DATE OF DEATH |  | 2jz. DATE OF DEATH |  | 2ka. DATE OF DEATH |  | 2kb. DATE OF DEATH |  | 2kc. DATE OF DEATH |  | 2kd. DATE OF DEATH |  | 2ke. DATE OF DEATH |  | 2kf. DATE OF DEATH |  | 2kg. DATE OF DEATH |  | 2kh. DATE OF DEATH |  | 2ki. DATE OF DEATH |  | 2kj. DATE OF DEATH |  | 2kk. DATE OF DEATH |  | 2kl. DATE OF DEATH |  | 2km. DATE OF DEATH |  | 2kn. DATE OF DEATH |  | 2ko. DATE OF DEATH |  | 2kp. DATE OF DEATH |  | 2kq. DATE OF DEATH |  | 2kr. DATE OF DEATH |  | 2ks. DATE OF DEATH |  | 2kt. DATE OF DEATH |  | 2ku. DATE OF DEATH |  | 2kv. DATE OF DEATH |  | 2kw. DATE OF DEATH |  | 2kx. DATE OF DEATH |  | 2ky. DATE OF DEATH |  | 2kz. DATE OF DEATH |  | 2la. DATE OF DEATH |  | 2lb. DATE OF DEATH |  | 2lc. DATE OF DEATH |  | 2ld. DATE OF DEATH |  | 2le. DATE OF DEATH |  | 2lf. DATE OF DEATH |  | 2lg. DATE OF DEATH |  | 2lh. DATE OF DEATH |  | 2li. DATE OF DEATH |  | 2lj. DATE OF DEATH |  | 2lk. DATE OF DEATH |  | 2ll. DATE OF DEATH |  | 2lm. DATE OF DEATH |  | 2ln. DATE OF DEATH |  | 2lo. DATE OF DEATH |  | 2lp. DATE OF DEATH |  | 2lq. DATE OF DEATH |  | 2lr. DATE OF DEATH |  | 2ls. DATE OF DEATH |  | 2lt. DATE OF DEATH |  | 2lu. DATE OF DEATH |  | 2lv. DATE OF DEATH |  | 2lw. DATE OF DEATH |  | 2lx. DATE OF DEATH |  | 2ly. DATE OF DEATH |  | 2lz. DATE OF DEATH |  | 2ma. DATE OF DEATH |  | 2mb. DATE OF DEATH |  | 2mc. DATE OF DEATH |  | 2md. DATE OF DEATH |  | 2me. DATE OF DEATH |  | 2mf. DATE OF DEATH |  | 2mg. DATE OF DEATH |  | 2mh. DATE OF DEATH |  | 2mi. DATE OF DEATH |  | 2mj. DATE OF DEATH |  | 2mk. DATE OF DEATH |  | 2ml. DATE OF DEATH |  | 2mn. DATE OF DEATH |  | 2mo. DATE OF DEATH |  | 2mp. DATE OF DEATH |  | 2mq. DATE OF DEATH |  | 2mr. DATE OF DEATH |  | 2ms. DATE OF DEATH |  | 2mt. DATE OF DEATH |  | 2mu. DATE OF DEATH |  | 2mv. DATE OF DEATH |  | 2mw. DATE OF DEATH |  | 2mx. DATE OF DEATH |  | 2my. DATE OF DEATH |  | 2mz. DATE OF DEATH |  | 2na. DATE OF DEATH |  | 2nb. DATE OF DEATH |  | 2nc. DATE OF DEATH |  | 2nd. DATE OF DEATH |  | 2ne. DATE OF DEATH |  | 2nf. DATE OF DEATH |  | 2ng. DATE OF DEATH |  | 2nh. DATE OF DEATH |  | 2ni. DATE OF DEATH |  | 2nj. DATE OF DEATH |  | 2nk. DATE OF DEATH |  | 2nl. DATE OF DEATH |  | 2nm. DATE OF DEATH |  | 2nn. DATE OF DEATH |  | 2no. DATE OF DEATH |  | 2np. DATE OF DEATH |  | 2nq. DATE OF DEATH |  | 2nr. DATE OF DEATH |  | 2ns. DATE OF DEATH |  | 2nt. DATE OF DEATH |  | 2nu. DATE OF DEATH |  | 2nv. DATE OF DEATH |  | 2nw. DATE OF DEATH |  | 2nx. DATE OF DEATH |  | 2ny. DATE OF DEATH |  | 2nz. DATE OF DEATH |  | 2oa. DATE OF DEATH |  | 2ob. DATE OF DEATH |  | 2oc. DATE OF DEATH |  | 2od. DATE OF DEATH |  | 2oe. DATE OF DEATH |  | 2of. DATE OF DEATH |  | 2og. DATE OF DEATH |  | 2oh. DATE OF DEATH |  | 2oi. DATE OF DEATH |  | 2oj. DATE OF DEATH |  | 2ok. DATE OF DEATH |  | 2ol. DATE OF DEATH |  | 2om. DATE OF DEATH |  | 2on. DATE OF DEATH |  | 2oo. DATE OF DEATH |  | 2op. DATE OF DEATH |  | 2oq. DATE OF DEATH |  | 2or. DATE OF DEATH |  | 2os. DATE OF DEATH |  | 2ot. DATE OF DEATH |  | 2ou. DATE OF DEATH |  | 2ov. DATE OF DEATH |  | 2ow. DATE OF DEATH |  | 2ox. DATE OF DEATH |  | 2oy. DATE OF DEATH |  | 2oz. DATE OF DEATH |  | 2pa. DATE OF DEATH |  | 2pb. DATE OF DEATH |  | 2pc. DATE OF DEATH |  | 2pd. DATE OF DEATH |  | 2pe. DATE OF DEATH |  | 2pf. DATE OF DEATH |  | 2pg. DATE OF DEATH |  | 2ph. DATE OF DEATH |  | 2pi. DATE OF DEATH |  | 2pj. DATE OF DEATH |  | 2pk. DATE OF DEATH |  | 2pl. DATE OF DEATH |  | 2pm. DATE OF DEATH |  | 2pn. DATE OF DEATH |  | 2po. DATE OF DEATH |  | 2pp. DATE OF DEATH |  | 2pq. DATE OF DEATH |  | 2pr. DATE OF DEATH |  | 2ps. DATE OF DEATH |  | 2pt. DATE OF DEATH |  | 2pu. DATE OF DEATH |  | 2pv. DATE OF DEATH |  | 2pw. DATE OF DEATH |  | 2px. DATE OF DEATH |  | 2py. DATE OF DEATH |  | 2pz. DATE OF DEATH |  | 2qa. DATE OF DEATH |  | 2qb. DATE OF DEATH |  | 2qc. DATE OF DEATH |  | 2qd. DATE OF DEATH |  | 2qe. DATE OF DEATH |  | 2qf. DATE OF DEATH |  | 2qg. DATE OF DEATH |  | 2qh. DATE OF DEATH |  | 2qi. DATE OF DEATH |  | 2qj. DATE OF DEATH |  | 2qk. DATE OF DEATH |  | 2ql. DATE OF DEATH |  | 2qm. DATE OF DEATH |  | 2qn. DATE OF DEATH |  | 2qo. DATE OF DEATH |  | 2qp. DATE OF DEATH |  | 2qq. DATE OF DEATH |  | 2qr. DATE OF DEATH |  | 2qs. DATE OF DEATH |  | 2qt. DATE OF DEATH |  | 2qu. DATE OF DEATH |  | 2qv. DATE OF DEATH |  | 2qw. DATE OF DEATH |  | 2qx. DATE OF DEATH |  | 2qy. DATE OF DEATH |  | 2qz. DATE OF DEATH |  | 2ra. DATE OF DEATH |  | 2rb. DATE OF DEATH |  | 2rc. DATE OF DEATH |  | 2rd. DATE OF DEATH |  | 2re. DATE OF DEATH |  | 2rf. DATE OF DEATH |  | 2rg. DATE OF DEATH |  | 2rh. DATE OF DEATH |  | 2ri. DATE OF DEATH |  | 2rj. DATE OF DEATH |  | 2rk. DATE OF DEATH |  | 2rl. DATE OF DEATH |  | 2rm. DATE OF DEATH |  | 2rn. DATE OF DEATH |  | 2ro. DATE OF DEATH |  | 2rp. DATE OF DEATH |  | 2rq. DATE OF DEATH |  | 2rr. DATE OF DEATH |  | 2rs. DATE OF DEATH |  | 2rt. DATE OF DEATH |  | 2ru. DATE OF DEATH |  | 2rv. DATE OF DEATH |  | 2rw. DATE OF DEATH |  | 2rx. DATE OF DEATH |  | 2ry. DATE OF DEATH |  | 2rz. DATE OF DEATH |  | 2sa. DATE OF DEATH |  | 2sb. DATE OF DEATH |  | 2sc. DATE OF DEATH |  | 2sd. DATE OF DEATH |  | 2se. DATE OF DEATH |  | 2sf. DATE OF DEATH |  | 2sg. DATE OF DEATH |  | 2sh. DATE OF DEATH |  | 2si. DATE OF DEATH |  | 2sj. DATE OF DEATH |  | 2sk. DATE OF DEATH |  | 2sl. DATE OF DEATH |  | 2sm. DATE OF DEATH |  | 2sn. DATE OF DEATH |  | 2so. DATE OF DEATH |  | 2sp. DATE OF DEATH |  | 2sq. DATE OF DEATH |  | 2sr. DATE OF DEATH |  | 2ss. DATE OF DEATH |  | 2st. DATE OF DEATH |  | 2su. DATE OF DEATH |  | 2sv. DATE OF DEATH |  | 2sw. DATE OF DEATH |  | 2sx. DATE OF DEATH |  | 2sy. DATE OF DEATH |  | 2sz. DATE OF DEATH |  | 2ta. DATE OF DEATH |  | 2tb. DATE OF DEATH |  | 2tc. DATE OF DEATH |  | 2td. DATE OF DEATH |  | 2te. DATE OF DEATH |  | 2tf. DATE OF DEATH |  | 2tg. DATE OF DEATH |  | 2th. DATE OF DEATH |  | 2ti. DATE OF DEATH |  | 2tj. DATE OF DEATH |  | 2tk. DATE OF DEATH |  | 2tl. DATE OF DEATH |  | 2tm. DATE OF DEATH |  | 2tn. DATE OF DEATH |  | 2to. DATE OF DEATH |  | 2tp. DATE OF DEATH |  | 2tq. DATE OF DEATH |  | 2tr. DATE OF DEATH |  | 2ts. DATE OF DEATH |  | 2tt. DATE OF DEATH |  | 2tu. DATE OF DEATH |  | 2tv. DATE OF DEATH |  | 2tw. DATE OF DEATH |  | 2tx. DATE OF DEATH |  | 2ty. DATE OF DEATH |  | 2tz. DATE OF DEATH |  | 2ua. DATE OF DEATH |  | 2ub. DATE OF DEATH |  | 2uc. DATE OF DEATH |  | 2ud. DATE OF DEATH |  | 2ue. DATE OF DEATH |  | 2uf. DATE OF DEATH |  | 2ug. DATE OF DEATH |  | 2uh. DATE OF DEATH |  | 2ui. DATE OF DEATH |  | 2uj. DATE OF DEATH |  | 2uk. DATE OF DEATH |  | 2ul. DATE OF DEATH |  | 2um. DATE OF DEATH |  | 2un. DATE OF DEATH |  | 2uo. DATE OF DEATH |  | 2up. DATE OF DEATH |  | 2uq. DATE OF DEATH |  | 2ur. DATE OF DEATH |  | 2us. DATE OF DEATH |  | 2ut. DATE OF DEATH |  | 2uu. DATE OF DEATH |  | 2uv. DATE OF DEATH |  | 2uw. DATE OF DEATH |  | 2ux. DATE OF DEATH |  | 2uy. DATE OF DEATH |  | 2uz. DATE OF DEATH |  | 2va. DATE OF DEATH |  | 2vb. DATE OF DEATH |  | 2vc. DATE OF DEATH |  | 2vd. DATE OF DEATH |  | 2ve. DATE OF DEATH |  | 2vf. DATE OF DEATH |  | 2vg. DATE OF DEATH |  | 2vh. DATE OF DEATH |  | 2vi. DATE OF DEATH |  | 2vj. DATE OF DEATH |  | 2vk. DATE OF DEATH |  | 2vl. DATE OF DEATH |  | 2vm. DATE OF DEATH |  | 2vn. DATE OF DEATH |  | 2vo. DATE OF DEATH |  | 2vp. DATE OF DEATH |  | 2vq. DATE OF DEATH |  | 2vr. DATE OF DEATH |  | 2vs. DATE OF DEATH |  | 2vt. DATE OF DEATH |  | 2vu. DATE OF DEATH |  | 2vv. DATE OF DEATH |  | 2vw. DATE OF DEATH |  | 2vx. DATE OF DEATH |  | 2vy. DATE OF DEATH |  | 2vz. DATE OF DEATH |  | 2wa. DATE OF DEATH |  | 2wb. DATE OF DEATH |  | 2wc. DATE OF DEATH |  | 2wd. DATE OF DEATH |  | 2we. DATE OF DEATH |  | 2wf. DATE OF DEATH |  | 2wg. DATE OF DEATH |  | 2wh. DATE OF DEATH |  | 2wi. DATE OF DEATH |  | 2wj. DATE OF DEATH |  | 2wk. DATE OF DEATH |  | 2wl. DATE OF DEATH |  | 2wm. DATE OF DEATH |  | 2wn. DATE OF DEATH |  | 2wo. DATE OF DEATH |  | 2wp. DATE OF DEATH |  | 2wq. DATE OF DEATH |  | 2wr. DATE OF DEATH |  | 2ws. DATE OF DEATH |  | 2wt. DATE OF DEATH |  | 2wu. DATE OF DEATH |  | 2wv. DATE OF DEATH |  | 2ww. DATE OF DEATH |  | 2wx. DATE OF DEATH |  | 2wy. DATE OF DEATH |  | 2wz. DATE OF DEATH |  | 2xa. DATE OF DEATH |  | 2xb. DATE OF DEATH |  | 2xc. DATE OF DEATH |  | 2xd. DATE OF DEATH |  | 2xe. DATE OF DEATH |  | 2xf. DATE OF DEATH |  | 2xg. DATE OF DEATH |  | 2xh. DATE OF DEATH |  | 2xi. DATE OF DEATH |  | 2xj. DATE OF DEATH |  | 2xk. DATE OF DEATH |  | 2xl. DATE OF DEATH |  | 2xm. DATE OF DEATH |  | 2xn. DATE OF DEATH |  | 2xo. DATE OF DEATH |  | 2xp. DATE OF DEATH |  | 2xq. DATE OF DEATH |  | 2xr. DATE OF DEATH |  | 2xs. DATE OF DEATH |  | 2xt. DATE OF DEATH |  | 2xu. DATE OF DEATH |  | 2xv. DATE OF DEATH |  | 2xw. DATE OF DEATH |  | 2xx. DATE OF DEATH |  | 2xy. DATE OF DEATH |  | 2xz. DATE OF DEATH |  | 2ya. DATE OF DEATH |  | 2yb. DATE OF DEATH |  | 2yc. DATE OF DEATH |  | 2yd. DATE OF DEATH |  | 2ye. DATE OF DEATH |  | 2yf. DATE OF DEATH |  | 2yg. DATE OF DEATH |  | 2yh. DATE OF DEATH |  | 2yi. DATE OF DEATH |  | 2yj. DATE OF DEATH |  | 2yk. DATE OF DEATH |  | 2yl. DATE OF DEATH |  | 2ym. DATE OF DEATH |  | 2yn. DATE OF DEATH |  | 2yo. DATE OF DEATH |  | 2yp. DATE OF DEATH |  | 2yq. DATE OF DEATH |  | 2yr. DATE OF DEATH |  | 2ys. DATE OF DEATH |  | 2yt. DATE OF DEATH |  | 2yu. DATE OF DEATH |  | 2yv. DATE OF DEATH |  | 2yw. DATE OF DEATH |  | 2yx. DATE OF DEATH |  | 2yy. DATE OF DEATH |  | 2yz. DATE OF DEATH |  | 2za. DATE OF DEATH |  | 2zb. DATE OF DEATH |  | 2zc. DATE OF DEATH |  | 2zd. DATE OF DEATH |  | 2ze. DATE OF DEATH |  | 2zf. DATE OF DEATH |  | 2zg. DATE OF DEATH |  | 2zh. DATE OF DEATH |  | 2zi. DATE OF DEATH |  | 2zj. DATE OF DEATH |  | 2zk. DATE OF DEATH |  | 2zl. DATE OF DEATH |  | 2zm. DATE OF DEATH |  | 2zn. DATE OF DEATH |  | 2zo. DATE OF DEATH |  | 2zp. DATE OF DEATH |  | 2zq. DATE OF DEATH |  | 2zr. DATE OF DEATH |  | 2zs. DATE OF DEATH |  | 2zt. DATE OF DEATH |  | 2zu. DATE OF DEATH |  | 2zv. DATE OF DEATH |  | 2zw. DATE OF DEATH |  | 2zx. DATE OF DEATH |  | 2zy. DATE OF DEATH |  | 2zz. DATE OF DEATH |  |
|--------------------|--|-------------------------------------|--|---------------|--|--------------|--|----------------|--|-------------------------|--|-------------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|-------------------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MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4291 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Chronic Myocardial Dis.</u><br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>None</u>  |  |  |  |
| 19a. DATE OF OPERATION<br><u>None</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?          |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  |
| 21c. HOW INJURY OCC   |  |  |  |

19-04137

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  | REG. NO. 79-04738                            |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>FRANCES A MCCARTHY  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2/9/79  |  | 2b. HOUR MIN.<br>11:50 PM   |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>8 6 1920   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS  |  | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                             |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Gov. Empl.       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE D. C.  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN Washington  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William Harris   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bertha Dunbar   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>579-18-8258  |  | 17 INFORMANT ADDRESS<br>Engene McCarthy 2113 34th St. S. E.  |  |   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4413 RUPTURED ABDOMINAL ANEURYSM<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) GENERALIZED ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)                  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>MODERATE HYPERTENSION   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>2-9-79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ruptured Abdominal Aneurysm                                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-7-79 to 2-9-79, that (I) (we) last saw the deceased alive on 2-9-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Roland Imperial MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br>2-11-79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROLAND IMPERIAL MD  |  |  |  | 22e. ADDRESS<br>4977 BATTERY LANE BETHESDA MD 20814  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-13-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem. Cem.  |  | 23d. LOCATION CITY OR TOWN<br>Suitland  |  | COUNTY STATE<br>Md.   |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br>W. ERNEST JACOBSON   |  |  |  | ADDRESS<br>1432 Yew St. N.W.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]    |  |

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| STATE OF MARYLAND   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
|---|---------|--|--|------------------------------------|------------------|-----------------------|--------------------------|--------------------------------------|----------|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| REG. NO. 79-04739   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE                             |                  | LAST                  |                          | 2a. DATE KNOWN OF DEATH              |          | 2b. HOUR                                     |  |
| Jack  |         | S.   |  | McCormick                          |                  |                       |                          | 2. 12 19 79                          |          | 11:19 AM                                     |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)                  | IF UNDER 24 YRS. |                       | 2c. DATE PRONOUNCED DEAD |                                      | 2d. HOUR |  |  |
| Male  | White   | 1-19-29  |  | 50 YRS.                            |                  |                       | Feb-12 1979              |                                      | 11:19 AM |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED                         |                  | NEVER MARRIED         |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH |          | MD.  |  |
| Indiana   |         | U.S.A.   |  | WIDOWED                            |                  | DIVORCED              |                          | Montgomery Co                        |          |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |                                    |                  | 12a. USUAL OCCUPATION |                          | 12b. KIND OF BUSINESS OR INDUSTRY    |          |  |  |
| Bethesda  |         | Suburban Hospital  |  |                                    |                  | Ecologist             |                          | Consulting                           |          |  |  |
| 13a. STATE  |         | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?           |                  | 13d. STREET ADDRESS   |                          |                                      |          |  |  |
| Maryland  |         | Montgomery   |  | Bethesda                           |                  | YES                   |                          | 8028 Fenway Drive                    |          |  |  |
| 14. FATHER'S NAME   |         | FIRST  |  | MIDDLE                             |                  | LAST                  |                          | 15. MOTHER'S MAIDEN NAME             |          | FIRST MIDDLE LAST                            |  |
| James   |         | A.   |  | McCormick                          |                  |                       |                          | Betty                                |          | Sovern                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT                      |                  | ADDRESS               |                          |                                      |          |  |  |
| No  |         | 317-24-1363  |  | Janet B. McCormick                 |                  | Same as #13           |                          |                                      |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:  |         |  |  |                                    |                  |                       |                          |                                      |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| (b) Cardio-Vascular Disease -   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| (c)   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                         |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |                                    |                  |                       |                          | 20. AUTOPSY?                         |          |  |  |
|   |         |  |  |                                    |                  |                       |                          | YES                                  |          | NO   |  |
| 21a. EXTERNAL CAUSE WAS   |         | 21b. TIME OF INJURY                                      |  | 21c. HOW INJURY OCCURRED           |                  |                       |                          |                                      |          |  |  |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |         | HOUR A.M. MONTH DAY YEAR                                 |  | P.M. 19                            |                  |                       |                          |                                      |          |  |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY                                     |  | 21f. LOCATION                      |                  |                       |                          |                                      |          |  |  |
| WHILE AT WORK   |         | AT HOME, STREET, FACTORY, FARM, ETC.)                    |  | STREET                             |                  | CITY OR TOWN          |                          | COUNTY                               |          | STATE  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident Suicide Homicide Undetermined manner |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| Autopsy Inspection Inquiry and in my opinion  |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| Actual Signature John G. Ball M.D. Title (Specify) Deputy Medical Examiner Date Signed Feb 12, 1979   |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| Examiner's Name John G. Ball, M.D. Address 7936 Old Georgetown Rd., Beth, MD  |         |  |  |                                    |                  |                       |                          |                                      |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |                  | 23d. LOCATION         |                          | COUNTY                               |          | STATE  |  |
| Cremation   |         | 2/17/79  |  | Metropolitan Crematory             |                  | Alexandria, Virginia  |                          |                                      |          |  |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR                            |  | 25b. REGISTRAR'S SIGNATURE         |                  |                       |                          |                                      |          |  |  |
| NAME Robert A. Rumphrey Funeral Homes, P.A. Bethesda, Maryland  |         | FEB 21 1979  |  | P. H. McCreedy                     |                  |                       |                          |                                      |          |  |  |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04740

|   |  |  |  |  |   |  |  |  |                                    |  |  |
|---|--|--|--|--|---|--|--|--|------------------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ELSIE P. McCRAIN</b>  |  |  | 2a DATE OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>79</b>        |  |   | 2b HOUR<br><b>3:20 PM</b>  |  |  |                                    |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>CAUCASIAN</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>MAY</b> DAY <b>15</b> YEAR <b>1890</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |                                    | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>NO. CAROLINA</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |  |                                    |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>KENSINGTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KENSINGTON GARDEN N.H.</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |                                    |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONT. KENSINGTON</b> 13c. CITY OR TOWN <b>KENSINGTON</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>11325 MITSCHER ST.</b>   |  |  |                                    |  |  |
| 14. FATHER'S NAME<br>FIRST <b>JAMES</b> MIDDLE <b>ROBINSON</b> LAST <b></b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ALICE</b> MIDDLE <b>SLATE</b> LAST <b></b>  |   |  |  |  |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>249-01-8727</b>   |   | 17 INFORMANT<br><b>NELL JOHNSON</b>  |  | ADDRESS <b>SAME AS ITEMS # 13</b>  |                                    |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF, (b) <b>INTERMITTENT HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <b>INTERMITTENT HEART DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>YEARS</b><br><b>11</b> |  |  |  |  |   |  |  |  |                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |  |  |                                    |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                    |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>July 19, 1978</b> to <b>2/15, 1979</b> , that (I) (we) lost saw the deceased alive on <b>2/13, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |  |   |  |  |  |                                    |  |  |
| 22b. SIGNATURE<br><b>Thos G. Ward M.D.</b>  |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>2/11/79</b> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thos G. Ward</b>  |  |  | 22e. ADDRESS<br><b>6116 Rockwood, Bethesda, MD 20834</b>               |  |   |  |  |  |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>2/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEM</b> |  |  | 23d. LOCATION<br>CITY OR TOWN <b>SUITLAND</b> COUNTY <b>P.G.</b> STATE <b>MD.</b>  |                                    |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>W. W. CHAMBERS CO.</b> ADDRESS <b>SILVER SPRING MARYLAND</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1979</b>                    |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>H. J. McBrady</b>   |  |  |                                    |  |  |

04240-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death.

With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04741

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |                                    |  |  |  |   |   |  |   |  |
|---|--|---|--|---|------------------------------------|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Martin Mc Donnell</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2 28 79</i>                  |   | 2b. HOUR<br>MIN<br><i>6 23 A M</i> |  |  |  |   |   |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>white</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 21 1913</i>  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><i>65</i>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><i>0 0</i>  |   | 8. IF UNDER 24 HRS<br>HOURS MIN<br><i>0 0</i>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, DC</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.  |  |  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Electrician</i>  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. DoD</i>   |  |  |   |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  |   |  |   |                                    | 13b. COUNTY<br><i>Montgomery</i>   |  | 13c. CITY OR TOWN<br><i>Sil. Spring</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>733 Sligo Avenue,</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Maurice McDonnell</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sarah Jane Ward</i>   |                                    |  |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>yes</i>  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW 11</i>   |                                    | 17. INFORMANT<br>ADDRESS<br><i>3400 Chatham Rd</i>   |  |  |   | 17. INFORMANT<br>NAME<br><i>Alice D. McDonnell-sister- Adelphi, Md.</i>                         |  |   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>ACUTE PULMONARY EDEMA</i>   |  |   |  |   |                                    |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>24 HRS.</i>                               |  |   |  |
| 303-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CHRONIC MALNUTRITION + DEHYDRATION</i>  |  |   |  |   |                                    |  |  |  |   | <i>5 WKS.</i>   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>CHRONIC ALCOHOLISM</i>   |  |   |  |   |                                    |  |  |  |   | <i>YEARS.</i>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>CHRONIC OBSTRUCTIVE LUNG DISEASE.</i>   |  |   |  |   |                                    |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>7 19 79</i>      |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |   |  |
| 22a. I certify that (b) (this hospital) attended the deceased from <i>July 19 76</i> to <i>Feb 28 19 79</i> , that (b) (we) last saw the deceased alive on <i>Feb 27 19 79</i> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |   |  |   |                                    |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>James Coleman MD</i>   |  |   |  |   |                                    | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br><i>2-28-79</i>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES R. COLEMAN</i>  |  |   |  |   |                                    | 22e. ADDRESS<br><i>9241 COLUMBIA BLVD<br/>SILVER SPRING, MD. 20910</i>   |  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>3-3-1979</i>   |   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Sil. Spr. Montgomery Md.</i> |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Warner E. Pumphrey, Inc.</i>   |  |   |  |   |                                    | 25. DATE REC'D. BY REGISTRAR<br><i>MAR 7 1979</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia McCreedy</i>                        |   |  |   |  |
| 8434 Ga. Ave., S.S. Md.   |  |   |  |   |                                    |  |  |  |   |   |  |   |  |



14540-01



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04742

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |  |   |   |  |  |  |  |
|---|--|--|---|--|---|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>NOEL ALBERT McGAURAN</b>  |  |  | 2a DATE OF DEATH<br>MONTH <b>2</b> DAY <b>2</b> YEAR <b>79</b>                      |  |   | 2b HOUR<br><b>4 AM</b>  |  |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>25</b> YEAR <b>97</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS <b>81</b> DAYS <b>81</b> HOURS <b>81</b> MIN <b>81</b>   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ill.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b> MD.                       |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1614 Oakview Drive</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b>  |  |  |
| 13a STATE<br><b>md.</b>   |  |  | 13b COUNTY<br><b>Mntgmy.</b>  |  | 13c CITY OR TOWN<br><b>Silv. Spr.</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>1614 Oakview Dr</b> |  |
| 14 FATHER'S NAME<br>FIRST <b>Richard</b> MIDDLE <b>McGauran</b> LAST <b>McGauran</b>  |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Nellie</b> MIDDLE <b>Hines</b> LAST <b>Hines</b>          |   |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>               |  | 17 INFORMANT<br>ADDRESS<br><b>Helen McGauran, wife - same.</b>                                |   |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myeloblastic leukemia</b><br>2050<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>undeterm.</b> |  |  |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>  |  |  |   |  |   |   |  |  |  |  |
| 19a DATE OF OPERATION<br><b>N/A</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>                      |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b> <b>19</b>             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>  |   |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/><br><b>N/A</b>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f. LOCATION<br>STREET <b>N/A</b> CITY OR TOWN <b>N/A</b> COUNTY <b>N/A</b> STATE <b>N/A</b> |   |  |  |  |  |
| 22a. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>Oct 59</b> to <b>Feb 2</b> 19 <b>79</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Feb 1</b> 19 <b>79</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) (did not) view the body after death.  |  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>William F. Simpson</b>   |  |  |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/1/79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William F. Simpson, MD</b>  |  |  |   |  | 22e. ADDRESS<br><b>8106 N.H. Ave. Silv. Spr. Md 20903</b>                                     |   |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b DATE<br><b>Feb. 5, 1979</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>                                 |   | 23d LOCATION<br>CITY OR TOWN <b>Fredericksburg</b> COUNTY <b>Spotsylvania</b> STATE <b>VA.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Francis J. Collins</b><br><b>500 University Blvd., W. Silver Spring, Md.</b>  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

52-04545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                                    |  |   | 79-04743 |  |
|--|--|--|--|---|--|---|------------------------------------|--|---|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |                                    |  |   | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Irene J. McQuillan   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/16/79             |   |                                    | 2b. HOUR<br>6:20 AM  |   |          |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/24/03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                  |                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>R. I.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                      |                                    |  |   |          |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care, Wheaton |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gov'n't   |   |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY<br>Montgomery                                  |   | 13c. CITY OR TOWN<br>Silver Spring |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael J. Donahue   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Eleanor Higgins |   |                                    |  |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>013 12 2918   |  | 17. INFORMANT ADDRESS<br>Martha Schwer (Same as 13e)  |  |   |                                    |  |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute cerebral vascular accident</u><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Cerebral arteriosclerosis</u><br>(c) <u>Due to, or as a consequence of</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs</u><br><u>2 m</u> |  |  |  |   |  |   |                                    |  |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |   |                                    |  |   |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                    |  |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                    |  |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>76</u> , to <u>2/16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>2/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.   |  |  |  |   |  |   |                                    |  |   |          |  |
| 22b. SIGNATURE<br><u>Myron L. Lenkin</u>   |  | DEGREE   |  | 22c. DATE SIGNED<br><u>2/16/79</u>  |  |   |                                    |  |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Myron L. Lenkin, M.D.</u>  |  | 22e. ADDRESS<br><u>2309 Shorefield Rd</u><br><u>Wheaton, Md. 20902</u>   |  |   |  |   |                                    |  |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/20/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Hood Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Chestnut Hill, Mass           |                                    |  |   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Tyson Wheeler Funeral Home, Rockville, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCready</u>                       |                                    |  |   |          |  |

64740-25

**Discussion**

STAINS

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7. 1. 1950

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04744

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Donald E McQuown</u>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>2-1-79</u> |   |  | 2b. HOUR<br><u>2:00 A.M.</u>  |  |  |  |
| 3. SEX<br><u>male</u>   |  | 4. RACE<br><u>white</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>June 7 1917</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>66</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Pennsylvania</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Holy Cross Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Contracting Officer NASA</u>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Montgomery</u>  |  | 13c. CITY OR TOWN<br><u>Silver Spring</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><u>1802 Sherwood Road</u>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Frank McQuown</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Frances Elizabeth Clemens</u>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>WWII</u>  |  | 17. INFORMANT<br><u>wife</u>  |  | ADDRESS<br><u>same as 13</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma of colon</u>                               |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>15'</u><br><u>3 min</u><br><u>15 min</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Pernicious Anemia (According to total gastrectomy)</u>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/1956</u> to <u>2/1/1979</u> , that (I) (we) last saw the deceased alive on <u>1/31/1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Stephen N. Jones, M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>2/1/79</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Stephen N. Jones, M.D.</u>  |  |   |  | 22e. ADDRESS<br><u>809 Viers Mill Road Rockville, Md.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>Feb. 5, 1979</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Rockville Mont. Md.</u>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Francis J. Collins</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 5 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Tracy McQuown</u>  |  |  |  |
| 500 University Blvd., W. Silver Spring, Md.   |  |   |  |   |  |   |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

72-0174

Rev.

1997-1998

2015-2016

Feb. 2, 1979 Prof. James Thompson

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FRANCIS J. COLEMAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 79-04745   |  |   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |   |  |
| ROSE B. MEEGAN  |  |  |  | 2 9 79   |  |  |  | 5 AM   |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |
| Female  |  | Caucasian  |  | Feb. 28, 1906  |  | 72 YRS.  |  | MONTHS   |  | DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |   |  |
| New York  |  | U.S.A.   |  |  |  | Montgomery County MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| Rockville   |  | Rockville Nursing Home   |  |  |  | Homemaker  |  | Home   |  |   |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                                       |  |
| Florida   |  |  |  | Palm Beach   |  | Highland Beach   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 3100 Ocean Boulevard                                      |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  | 16. ADDRESS  |  |   |  |
| Josef Bleha   |  |  |  | Kathrine Novak   |  |  |  | Rockville, Maryland  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |  |  |   |  |
| no  |  |  |  | 215-22-2569  |  | Carolyn M. Huard 873 Azalea Drive  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u><br>3319<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain atrophy and dehydration</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | CITY OR TOWN COUNTY STATE  |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  | STREET   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-29-</u> 19 <u>77</u> , to <u>2-9-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2-3-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| <u>[Signature]</u>  |  |  |  | M.D.   |  |  |  |  |  | 2-9-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |
| KWANG S. KIM  |  |  |  | 615 W. Montgomery Ave, Rockville   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | CITY OR TOWN COUNTY STATE  |  |   |  |
| Cremation   |  | 2/14/79  |  | Newton Cem. Crematory, Newton  |  | Massachusetts  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 24b. DATE REC'D BY REGISTRAR   |  |  |  | 24c. REGISTRAR'S SIGNATURE   |  |   |  |
| Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland  |  |  |  |  |  |  |  |  |  |   |  |

BP

*[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |  |   |  |   | REG. NO. 79-04746   |  |
|--|--|--|---|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Victor Mario Mercoigliano   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 28 79  |   |   | 2b. HOUR<br>10 <sup>15</sup> AM  |   |  |   |   |  |
| 3 SEX<br>male  |  | 4 RACE<br>W  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 1 22  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ADMINISTRATIVE   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>LAW JUDGE   |   |   |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>MONTGOMERY   |   | 13c. CITY OR TOWN<br>SILVER SPRING                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9812 BRADDOCK ROAD |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ANGELO C. MERCOGLIANO  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LILLIAN E. RICCI   |   |   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |   | 17. INFORMANT<br>ADDRESS<br>GERTRUDE MEROGLIANO SAME AS 13 WIFE |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepa Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Cancer Pancreas</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>1579 |  |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 wks<br>2 months |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br>12-17-78   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bowel obstruction   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>78</u> , to <u>2-28</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Robert A. Smith  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>3/1/79   |   |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS<br>8314 NW Blvd. E. SS. Md   |   |   |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>3/3/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.                            |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McBrady  |   |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |   |   |   |  |   |  |   |   |  |

RECEIVED

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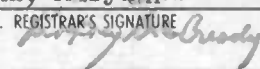
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 42 hours after death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Frances J. Millar</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>2</b> Year <b>1979</b> |   |  | 2b. HOUR<br><b>11:00</b> PM   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>August 29, 1882</b>  |  | 6. AGE (In years last birthday)<br><b>96</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Bethesda Health Care Center</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ret. Fitter-Lansburgh's Dept. Sto</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6100-Wilmet Road</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>John - Mills</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary - Skidmore</b>     |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-01-7032</b>   |  | 17. INFORMANT Address<br><b>Marion J. Collinge-daughter Same as # 13</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal cerebral Thrombosis</b><br><b>4340</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , 19____, to <b>2/2/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>2/1/79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><br><b>OSOOTH LEKAGUL MD</b>   |  | 22c. DATE SIGNED<br><b>2/3/79</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>OSOOTH LEKAGUL MD</b>  |  | 22e. ADDRESS<br><b>74 W. Arlington Rd Bethesda Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 5, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b>                      |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>J. Wm. Lee's Sons Co., 300-4th St., NE, Wash., D.C.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
|---|--|------------------|--|---|--|---|--|---|--|---|--|---|--|---------------------|--|----------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| REG. NO. 79-04748   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Alice L. Miller   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH                   |  | 2b. DATE OF DEATH   |  | 2c. DATE OF DEATH   |  | 2d. HOUR |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cauc. |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-18-01   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>77 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2-17-79   |  | 2d. HOUR<br>5:55 PM |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Colorado   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY Co. MD.                                      |  |                     |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |                     |  |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Montgomery   |  |   |  | 13c. CITY OR TOWN<br>Chevy Chase  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William M. Casey  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel Cutshaw  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>231-22-9465   |  |                     |  |          |  |
| 17. INFORMANT<br>Richard D. Miller  |  |                  |  | ADDRESS<br>Same as 13   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| PART I DEATH WAS CAUSED BY:   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia - Rt Lung -</u>  |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| (b) <u>Pulmonary Embolism</u>   |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| (c) <u>Fracture, Left Hip + Left Humerus</u>  |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>C.V.A. with Left Hemiparesis - Metastatic Bone disease from Ca. of Left Breast</u>  |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                     |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:30 am 2-11-79  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><u>Fall in bathroom</u>  |  |   |  |   |  |                     |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><u>Nursing Home</u>  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>5215 Cedar Lane Bethesda Montgomery Md.</u>   |  |   |  |   |  |                     |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| ACTUAL SIGNATURE<br><u>John G. Ball</u>   |  |                  |  | TITLE (SPECIFY)<br>M.D. <u>Deputy</u>   |  |   |  | MEDICAL EXAMINER<br>7936 Old Georgetown Road<br>Bethesda, Maryland 20014  |  |   |  | DATE SIGNED<br><u>Feb. 17, 1979</u>   |  |                     |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>John G. Ball   |  |                  |  | ADDRESS<br>Bethesda, Maryland 20014   |  |   |  |   |  |   |  |   |  |                     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |                  |  | 23b. DATE<br>2-18-79  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia                              |  |                     |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY<br>HOMES. P. A., Bethesda, Maryland  |  |                  |  | ADDRESS<br>Bethesda, Maryland   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1979  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Mary McCreedy</u>  |  |                     |  |          |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04749

|  |  |   |   |   |                                      |   |   |  |  |
|--|--|---|---|---|--------------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HYMAN R. MILLER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>12</b> YEAR <b>79</b>                    |   |                                      | 2b. HOUR<br><b>7 A.M.</b>   |   |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH <b>FEB.</b> DAY <b>22</b> YEAR <b>1886</b>   |                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS                                       |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                          |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HEBREW HOME OF GREATER WASHINGTON</b> |   |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>merchant</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b>  |  |   | 13b. COUNTY <b>MONTGOMERY</b>   |   | 13c. CITY OR TOWN <b>SIL. SPRING</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST <b>FROYEM</b> MIDDLE <b></b> LAST <b>MILLER</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>BLOOMA</b> MIDDLE <b></b> LAST <b>(Unknown)</b> |   |                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>        |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>577-36-0084</b>   |  |   | 17. INFORMANT<br>ADDRESS <b>FRANCES M. WALDMAN (SAME AS #13)</b>                    |   |                                      |   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>            |  |   |   |   |                                      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SEVERE ORGANIC BRAIN SYNDROME</b>  |  |   |   |   |                                      |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |   |   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>No</b>   |  | 21b. TIME OF INJURY<br>HOUR A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b><br>P.M. <b></b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b>   |                                      |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>   |   | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |                                      |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/7/79</b> , 19 <b>77</b> , to <b>2/12/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/12/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                                      |   |   |  |  |
| 22b. SIGNATURE<br><b>D. D. Patel</b>   |  |   |   | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      |   |   | 22c. DATE SIGNED<br><b>2/12/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. D. PATEL</b>  |  |   |   | 22e. ADDRESS<br><b>6121 Montrose Rd. Rockville, MD.</b>   |                                      |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 14, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT LEBANON</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN <b>ADELPHI</b> COUNTY <b>P.G.</b> STATE <b>MARYLAND</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>RONALD M. STEIN</b> ADDRESS <b>HEBREW MEMORIAL F. H. 232 CARROLL STREET, N. W. WASH. D. C. 20012</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 15 1979</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Pietro McCreedy</b>                                  |   |  |  |

10-04742



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04750

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joe E. Miller</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 2, 1979</b> |  |  | 2b. HOUR<br><b>4:45 PM</b>   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11/18/36</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9717 Bellevue Drive</b> |   |  | 12a. USUAL OCCUPATION<br><b>Vice President</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Standard Fed. Savings &amp; Loan Assn.</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joe E. Miller</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Oakes</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>1955-1963</b>   |   | 17. INFORMANT ADDRESS<br><b>Robert L. Douglass, same as #13</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PRIMARY MVO CARDIOPATHY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6</b> , 19 <b>78</b> , to <b>2-2</b> , 19 <b>79</b> , that (I) (we) lost <b>2-1</b> saw the deceased alive on <b>2-1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>John C. Seymour M.D.</b>   |  |  |   | DEGREE <b>M.D.</b>   |  | 22c. DATE SIGNED <b>2-3-79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN C. SEYMOUR M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>5480 WISC. AVE. CH. CH. MD. 20015</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>2/4/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestview Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Wichita Falls, Texas</b>   |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A.</b>   |  |  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>FEB 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Mary McBrady</b>  |  |  |
| 25c. ADDRESS<br><b>7557 Wisconsin Ave., Bethesda, MD</b>   |  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

78-04720

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

APR 11 1978

MEMPHIS

TO DIRECTOR

FROM

SA [Name]

SA [Name]

SA [Name]

SA [Name]

RE [Subject]

RE [Subject]

RE [Subject]

RE [Subject]

ON [Date]

ON [Date]

ON [Date]

ON [Date]

AT [Location]

AT [Location]

AT [Location]

AT [Location]

BY

BY

BY

BY

FOR [Purpose]

IN [Location]

ON [Date]

AT [Location]

BY [Name]

FOR [Purpose]

IN [Location]

ON [Date]

AT [Location]

BY [Name]

FOR [Purpose]

IN [Location]

ON [Date]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  | REG. NO. 79-04751  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) <b>Eksie- Mintz</b>   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>2</b> DAY <b>27</b> YEAR <b>1979</b>             |  | 2b. HOUR <b>2:53 PM</b>  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>W.</b>  |  | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>21</b> YEAR <b>07</b>  |  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>71</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD MONTH <b>2</b> DAY <b>27</b> YEAR <b>1979</b>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Buyer (Retired)</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Clo.</b>  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Chevy Chase</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  | 13e. STREET ADDRESS <b>3505 Taylor Street</b>   |  |  |  |
| 14. FATHER'S NAME FIRST <b>Morris</b> MIDDLE <b>-----</b> LAST <b>Mintz</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>-----</b> LAST <b>(unknown)</b>  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>-----</b> |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>578-10-4972A</b>   |  |  |  | 17. INFORMANT <b>Nathan Mintz</b>  |  |   |  | ADDRESS <b>Silver Spring, Md. 10612 Cavalier Drive</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest - Shock.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>8199</b><br>(b) <b>Massive Hemorrhage.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rupture of Aorta + Left Ventricle.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10 PM 2-27-1979</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Auto Accident</b>                  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>  |  | 21f. LOCATION STREET <b>Jones Bridge Rd.</b> CITY OR TOWN <b>Bethesda</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b> |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                  |  |  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>   |  |  |  | TITLE (SPECIFY) <b>Deputy</b> M.D.   |  |   |  | MEDICAL EXAMINER  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN G. BALL, M.D.</b>  |  |  |  | ADDRESS <b>-----</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3-1-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>   |  |   |  | 23d. LOCATION CITY OR TOWN <b>Falls Church</b> COUNTY <b>Virginia</b> STATE <b>-----</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels</b> ADDRESS <b>1170 Rockville Pike</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>-----</b>   |  |   |  |  |  |

12710-25



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO. <b>79-04752</b>   |   |  |   |  |
|--|--|--|--|---|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Clayton - MORRIS</b>   |  |  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 27, 1979</b> |  |  | 2b. HOUR<br><b>7:00A M</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 20, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.</b> MD.  |  |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clarksburg</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>23101 Frederick Rd.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  |   |  |  | 13b. COUNTY<br><b>Montgomery</b>                         |  | 13c. CITY OR TOWN<br><b>Clarksburg</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>23101 Frederick Rd.</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Sebert Morris</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Clemintine Knight</b>  |  |  |  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>225-14-1456</b>  |  | 17. INFORMANT<br><b>Jesse J. Morris</b> <b>23101 Frederick Road</b><br><b>Clarksburg, Maryland 20734</b>   |  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCD with atrial fib. and chronic C.H.F.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 yrs.</b>  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 71</b> to <b>Feb. 27</b> 19 <b>79</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Dec. 12</b> 19 <b>78</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Frederick Moomau M.D.</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-27-79</b>   |  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick Moomau, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>18111 Prince Phillip Dr., Olney, Md. 20832</b>  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>March 2, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monocacy Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Beallsville Montg. Md.</b>          |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Molesworth Funeral Home</b>   |  |  |  |   |  | ADDRESS<br><b>Damascus, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1979</b>                                   |  |  |   |  |   |  |
|  |  |  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>                                |  |  |   |  |   |  |

78-04125

400:7

1901, 1902

1901

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Clifton

1901

April 20, 1901

White

Male

Montgomery, No.

828

Virginia

Robert

23101 Frederick St.

Clarksburg

23101 Frederick St.

1

Montgomery Clarksburg

Virginia

1901

Clarksburg

Robert

23002

23101 Frederick St.

231-14-1-25 Robert Clarksburg, Virginia

no

Robert Clarksburg, I.D.

March 2, 1901 Montgomery Clarksburg, Virginia

Robert

Clarksburg, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 79-04753   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Elmer Siebert MORRIS   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 28, 1979   |  | 2b. HOUR<br>12:10 P.  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 13, 1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co. MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Boys   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>RUBY Drive |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Parks  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Gaithersburg  |  |  |  |   |  |  |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Siebert - Morris   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Clementine Knight  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>14 W. Deer Park Dr., Apt. 301   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>W.W. 2   |  | 17. INFORMANT ADDRESS<br>Gladys I. Morris, Item 13  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4292</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ASCD, chronic alcoholism</u><br>(c) <u>due to OR AS A CONSEQUENCE OF</u><br>DUE TO OR AS A CONSEQUENCE OF |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>yrs</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Laryngeal carcinoma</u>   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>2/2/79</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>79</u> , to <u>present</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/2/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Robert Millman</u>   |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/1/79  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Millman, M.D.   |  |  |  | 22e. ADDRESS<br>15 E. Deer Park Dr., Gaithersburg, Md.  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2 Mar 79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Neelsville Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Germantown Montg. Md.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Olin L. Molesworth   |  |  |  | ADDRESS<br>Damascus, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McCreedy</u>   |  |   |  |

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"U.S. Census Bureau"

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                             |  |   |  |  |  |  |  | 79-04754<br>REG. NO.   |  |
|--|--|-----------------------------|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                             |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Joseph Rexmond Francis Morris</b>   |  |                             |  |   |  |  |  |  |  | 2b. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <b>Feb 6 1979</b>     |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>            |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb 8 1933</b>  |  | 6. AGE (IN YEARS) LAST BIRTHDAY<br><b>45 YRS.</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD <b>Feb 6 1979</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>   |  |                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD</b>                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  |                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>14714 Carrollton Rd</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PUBLIC ACCOUNTANT</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>                        |  |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Montg</b> |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>14714 Carrollton Rd</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM MORRIS</b>   |  |                             |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CATHERINE BRODERICK</b>                     |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |                             |  | 16b. SOCIAL SECURITY NO.<br><b>214-36-3406</b>  |  | 17. INFORMANT ADDRESS<br><b>HELEN L. MORRIS- WIFE- SAME AS 13e</b>                           |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>9554 Gunshot wound of Abdomen</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                             |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>None</b>  |  |                             |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>930 P.M. 26 1979 Shot self</b>  |  |                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>930 P.M. 26 1979</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>Carrollton Rd Rockville Montg MD</b>  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                             |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |  |                             |  | TITLE (SPECIFY)<br><b>M.D. Dep</b>  |  |  |  | DATE SIGNED<br><b>Feb 6 1979</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>JOHN S. ROGERS</b>   |  |                             |  | ADDRESS<br><b>1919 SEMINARY RD. STL. SPG., MD</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  |                             |  | 23b. DATE<br><b>FEB. 8, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREM.</b>                              |  |  | 23d. LOCATION<br><b>ALEXANDRIA FAIRFAX VA.</b> |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>FRANCIS J. COLLINS</b>   |  |                             |  | ADDRESS<br><b>500 UNIV. BLVD. WEST, STL. SPG., MD.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1979</b>   |  |  |  |
|  |  |                             |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McNeely</b>   |  |  |  |

10-04724

MADE IN MEXICO

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "MADE IN MEXICO" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 79-04755  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ethelwyn Cowin Morton</b>  |  |   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 16, 1979</b> |  |  | 2b. HOUR<br><b>1:37a</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 28, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Minnesota</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Sandy Spring</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>17300 Quaker Lane</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Cowin</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rhoda Catherine Moberly</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>219-48-2987</b>  |  | 17. INFORMANT ADDRESS<br><b>Harold S. Morton, Jr. Charlottesville, Va. 3500 Monacan Drive</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line (a, b, and c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>410- CARDIOGENIC SHOCK. 6 HRS.</b><br>DUE TO OR AS A CONSEQUENCE OF (b)<br><b>ACUTE MYOCARDIAL INFARCT 6 HRS.</b><br>DUE TO OR AS A CONSEQUENCE OF (c)<br><b>ASCHD. YES.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) |  |   |  |   |  |   |  |  |  |  |  |
| MEDICAL CERTIFICATION  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 1975</b> to <b>2/16/79</b> , that (I) (we) lost <b>2/15/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>D. R. Lewis</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/16/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. R. LEWIS MD</b>   |  |   |  | 22e. ADDRESS<br><b>OLNEY, MD 20832</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |   |  | 23b. DATE<br><b>2/17/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Crematory</b>                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood, P.G., Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hines/Rinaldi Funeral Home, Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1979</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |
| 11800 New Hampshire Ave., Silver Spring, Md.   |  |   |  |   |  |   |  |  |  |  |  |



22-04122

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 25M

(VR A 15 (4) 9/74)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |   | REG. NO. 79-04756             |  |
|---|--|--|--|---|--|---|--|---|---|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mark THERESA Motley  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-24-79   |  | 2b. HOUR<br>10 <sup>30</sup> AM   |   |                               |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 24 98  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co. MD.                                      |  |   |   |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Randolph Hills Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BOTANIST                    |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S.D.A. |                               |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2948 Hewitt Ave.   |   |                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas A. Keleher  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Frances J. Anthony   |  |   |  |   |  |   |   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-44-8342   |  | 17. INFORMANT ADDRESS<br>THOMAS EDWIN MOTLEY SAME AS 13 SON   |  |   |  |   |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac respiratory arrest</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>years</u> |  |  |  |   |  |   |  |   |   |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Aortic Stenosis. Senility.</u>  |  |  |  |   |  |   |  |   |   |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |   |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>February 27</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>February 20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |   |                               |  |
| 22b. SIGNATURE<br><u>Dr. Hugo G. Grandin</u>  |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>2-24-79   |   |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Hugo G. Grandin</u>   |  | 22e. ADDRESS<br><u>800 Rockville Dr - 303A</u><br><u>Silver Spring Md 20910</u>  |  |   |  |   |  |   |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/27/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NATIONAL  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ARLINGTON VIRGINIA                                |  |   |   |                               |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Francis J. Collins</u>   |   |                               |  |
| 25c. ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |   |  |   |  |   |   |                               |  |

3204 BP

19-0125

ADDRESS

ATTORNEY

NO

253-14-345 THOMAS EDWIN NOTLEY SAME AS 13

VIRGINIA

ARLINGTON

ARLINGTON NATIONAL

253-14-345

BUREAU

FRANCIS J. COLLIER

EX-101, D.V.O., SILVER SPRING, MD. 20907

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |  |  | REG. NO. 79-04757   |  |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                         |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Franklin G Moseley</b>  |  |                         |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 24 19 79</b> |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 4, 1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>49</b>                                  |  | IF UNDER 1 YR. MONTHS DAYS<br><b></b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>2 26 19 79</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>at home/4853 Cordell Avenue</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Computer Op.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                      |  |
| 13a. STATE<br><b>Md.</b>   |  |                         |  | 13b. COUNTY<br><b>Montg.</b>  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4853 Cordell Ave. #1511</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John M. Moseley</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sallie Mae Monk</b>               |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>419-42-3708</b>  |  | 17. INFORMANT ADDRESS<br><b>901 Sherrod Ave. Sallie Mae Moseley Florence, Ala.</b> |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>diabetes</b>   |  |                         |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>H. R. Guard</b>  |  |                         |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | DATE SIGNED <b>2/27/79</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn Street, Balto., MD-21201</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                         |  | 23b. DATE <b>Mar. 2, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenview Cem.</b>                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Florence, Montgomery, Ala.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>  |  |                         |  | ADDRESS <b>Homes, P.A. Bethesda, Md.</b>  |  |  |  | 25. REC'D. BY REGISTRAR <b>MAR 5 1979</b>  |  |   |  |
|  |  |                         |  |   |  |  |  | 26. REGISTRAR'S SIGNATURE <b>Litney McCreedy</b>   |  |   |  |

79-01527

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | REG. NO. 79-04758  |  |
|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |   |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Soula R. Munch   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>02/19/79  |  | 2b. HOUR<br>11:00A.M.  |
| 3 SEX<br>Female  | 4 RACE<br>WHITE   | 5 DATE OF BIRTH MONTH DAY YEAR<br>NOV 18, 1893<br><del>NOV 18, 1893</del>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>XXX 85 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ALABAMA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney, Md.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY<br>MONTGOMERY   | 13c. CITY OR TOWN<br>SILVER SPRING  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>15001 WESTHOLM COURT  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HENRY ROBINSON  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>VIENNA CLANTON                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>180-24-9850A  | 17. INFORMANT ADDRESS<br>JAMES C. MUNCH SAME AS 13 HUSBAND                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerotic Cerebral Disease</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2/19/79<br>1960<br>"   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (a) this hospital attended the deceased from <u>1st week Feb 1975</u> to <u>2/19</u> 19 <u>79</u> , that (b) (we) lost saw the deceased alive <u>above</u> (b) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Lewis Keller, MD</u>  |   | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/21/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lewis Keller, MD  |   | 22e. ADDRESS<br>1811 Prince Phillips Dr.<br>Olney, Md 20832   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |   | 23b. DATE<br>2/22/79  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>METROPOLITAN CREMATORY                         |  |
| 23d. LOCATION CITY OR TOWN<br>ALEXANDRIA   |   | COUNTY<br>Stafford  |   | STATE<br>VIRGINIA  |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS  |   | 25. DATE RECEIVED BY REGISTRAR<br>FEB 22 1979   |   |  |  |
| 500 UNIV BLVD, W, SILVER SPRING, MD, 20901   |   | 25b. REGISTRAR'S SIGNATURE  |   |  |  |

99-01728

1901  
1902  
1903

WHITE

U.S.A.

ALABAMA

INVESTMENT

1901 WESTINGHOUSE

WESTINGHOUSE STEEL CO. INC.

INDUSTRIAL

CLAYTON

THEYER

ROBERTSON

FRANK

SALE AS IS (REBUILT)

JAMES O. HANCOCK

190-01-0125

VIRGINIA

ALABAMA

WESTINGHOUSE

ALABAMA

CLAYTON

1901 WESTINGHOUSE STEEL CO. INC.



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

79-04759

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Adelia C. Nagenast</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 1, 1979</b>                             |   | 2b. HOUR<br><b>5:30 P M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9/27/1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>80</b>                                 | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assistant Buyer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hecht Co.</b>   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Pr. Geo.</b>  | 13c. CITY OR TOWN<br><b>Beltsville</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert J. Lorenz</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian Knauer</b>   |   | 13e. STREET ADDRESS<br><b>13114 Greenmount Avenue</b>                             |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-10-3534</b>  |   | 17. INFORMANT ADDRESS<br><b>Robert E. Saffran same as 13</b>                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive Cerebrovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>Jan 30 1979</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 30 1979</b> to <b>Feb 1 1979</b> , that (I) (we) last saw the deceased alive on <b>Feb 1 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |
| 22b. SIGNATURE DEGREE<br><b>Bernard A. Fitzgerald M.D.</b>   |  |   |   | 22c. DATE SIGNED<br><b>2-1-79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>  |  |   |   | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD E. SILVER SPRING MD</b>                    |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Feb. 5, 1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b>          |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Francis J. Collins</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>Feb 5 1979</b>                                | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McCready</b>   |

79-04729

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>STATE REGISTRAR   |  |                      |  |   |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                            |  | REG. NO. 79-04760   |  |   |  |
|--|--|----------------------|--|---|--|---|--|---|--|--|--|---|--|----------------------------|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Augustine Wills Neale   |  |                      |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>02/07/79                |  |   |  | 2b. HOUR<br>M  |  |   |  |                            |  |   |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>caucasian |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02/14/23  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>55 YRS.                 |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                               |  | 2c. DATE PRONOUNCED DEAD<br>2/7/79  |  | 2d. HOUR<br>4:35 PM        |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TENNESSEE   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD |  |   |  |                            |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>REALTOR  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DONOHUE CONST                                  |  |                            |  |   |  |   |  |
| 13a. STATE<br>MD   |  |                      |  |   |  |   |  |   |  |  |  | 13b. COUNTY<br>Mont   |  | 13c. CITY OR TOWN<br>Olney |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>3412 Colonial Ct |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RAPHAEL A. NEALE   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOUISE HERBERT |  |   |  |  |  |   |  |                            |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |                      |  | 16b. SOCIAL SECURITY NO.<br>WW II<br>577-10-3749  |  | 17. INFORMANT<br>MARIORIE LEE NEALE                             |  |   |  | ADDRESS<br>SAME AS 13 WIFE                                   |  |   |  |                            |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) <u>Chronic Myocardial Dis.</u><br>(c) <u>VRP</u>  |  |                      |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                            |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>None</u>   |  |                      |  |   |  |   |  |   |  |  |  |   |  |                            |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |                            |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE                      |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |   |  |  |  |   |  |                            |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>John S. Rogers</u>  |  |                      |  | TITLE (SPECIFY)<br>M.D. <u>Dep.</u>   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>Feb 7, 1979  |  |                            |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>JOHN S. ROGERS   |  |                      |  | ADDRESS<br>1919 SEMINARY ROAD, SILVER SPRING, MD.   |  |   |  |   |  |  |  |   |  |                            |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |                      |  | 23b. DATE<br>2/10/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN            |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>SILVER SPRING               |  |   |  | COUNTY<br>MONT             |  | STATE<br>MD.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Pietro A. Cuddy</u>         |  |   |  |                            |  |   |  |   |  |

FEB 9 1979

00710-07

10/07

1

U.S.A.

TEMPER

DATA

WEATHER

STATION

RECORDS

WATNELL

WALL

LOUSE

LEWIS

172

NO 11

577-10-2740

WATSON LEE WEALE

SALE AS 13 WITE

JOHN S. ROBERTS

1918 BENTLEY ROAD, SILVER SPRING, MD.

RECEIVED

2/10/79

GATE OF HEAVEN

SILVER SPRING

WOMEN

AND

FRANCIS J. COLLINS  
500 UNIT BLVD., SILVER SPRING, MD. 20901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR  |  |         |  |   |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |  |  |  |  |  |  | 79-04761 |  |
|--|--|---------|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  |   |  |  |  |  |  |  |  | 2b. HOUR |  |
| Fannie T. Newcome  |  |         |  |   |  |  |  |  |  | Feb 23, 1979   |  |   |  |  |  |  |  |  |  | 4:10 AM  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                            |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |  |  |  |  |          |  |
| F  |  | Blk     |  | Sept 21 00 78   |  | 78   |  | MONTHS   |  | DAYS   |  | Feb 23 1979   |  | 4:10 AM                                      |  |  |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |  |  |          |  |
| USA  |  |         |  | USA   |  |  |  | Montgomery MD  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |          |  |
| Syl. Spg   |  |         |  | Fairland Nursing Home   |  |  |  | Unk  |  |  |  | None  |  |  |  |  |  |  |  |          |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |          |  |
| MD   |  |         |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |         |  |   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| ISAIAH TALIFERRO   |  |         |  |   |  | HARRIET GANDLER                              |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  | 16b. SOCIAL SECURITY NO.                     |  |  |  |  |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |  |  |          |  |
| NO   |  |         |  |   |  | 245-58-2390                                  |  |  |  |  |  | THOMAS NEWCOMER SON   |  |  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial dis</u><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arterio cardiovascular dis.</u> yrs<br>(c) <u></u>  |  |         |  |   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Fracture L hip</u>   |  |         |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |          |  |
| 12-31-78   |  |         |  | Fracture L Hip  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY HOUR <u>12:30</u> MONTH <u>12</u> DAY <u>31</u> YEAR <u>78</u>                      |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |  |  |  |  |  |  |          |  |
|  |  |         |  | P.M.  |  |  |  | Fall   |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE)  |  |  |  |   |  |  |  |  |  |  |  |          |  |
|  |  |         |  | Nursing Home  |  |  |  | Fairland Rd. Syl. Spg. Mont Md   |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |  |  | DATE SIGNED  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| [Signature]  |  |         |  | M.D. [Signature]  |  |  |  | FEB 23 1979  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
|  |  |         |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE)                                       |  |  |  |  |  |  |  |          |  |
| BURIAL   |  |         |  | 2/27/79   |  |  |  | Church   |  |  |  | Rich Square, N. Calverton   |  |  |  |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  | ADDRESS   |  |  |  | 25. DATE REC'D. BY REGISTRAR   |  |  |  | 26. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |          |  |
| JOHN T. RHINES CO.   |  |         |  | 3015 15th St. N.E., D.C.  |  |  |  | MAR 2 1979   |  |  |  | [Signature]   |  |  |  |  |  |  |  |          |  |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 1.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04762

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| Billie L. Niedomanski  |  | February 15, 1979  |   | 1150 PM  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR   |  |
| Female   | Caucasian  | June 7, 1903   | 75  | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| South Carolina   | USA  |  | Montgomery, MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Bethesda   | Suburban Hospital  | Homemaker  |   | Home   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| Md.  | Montg.   | Bethesda   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4521 East West Highway   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |
| James R. Hunter  |  |  | Marv E. Hick  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |
| No   |  | 18-38-8452   |   | 17904 Archwood Way, Olney, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)  |  |  |   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Cardiac arrest (ventricular fibrillation) 12 hours   |  |  |   |  |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction 12 hours   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |   |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |   | 21f. LOCATION  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 79, to 2/16 19 79, that (I) (we) lost saw the deceased alive on 2/15 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| Barton J. Gershan, MD  |  |  |   | 2/16/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| Barton J. Gershan, M.D.  |  | 50 West Edmonston Dr. Rockville, Md.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | Feb. 20, 1979  |   | Gate of Heaven   |  |
| 23d. LOCATION  |  | 23e. DATE REC'D. BY REGISTRAR  |   |  |  |
| Silver Spring, Maryland  |  | FEB 23 1979  |   |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA MARYLAND  |  | FEB 23 1979  |   | [Signature]  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                  |  |   |  |   |  |   |  | 79-04763<br>REG. NO.  |  |   |  |
|---|--|----------------------------------|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VERA E. NOWITZKY</b>   |  |                                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>2-25-79</b> |  | 2b. HOUR<br><b>A. M.</b>                            |  |
| 3 SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 26, 1897</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>81</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br><b>Feb. 23, 1979</b>  |  | 2d. HOUR<br><b>8:50A</b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Minsk, Russia</b>   |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Russia</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4701 Willard Ave.,</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b> |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                                  |  |   |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b> |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4701 Willard Ave.,</b>  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eustan Washkevich</b>  |  |                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Euphemia (Unknown)</b>  |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                                  |  | 16b. SOCIAL SECURITY NO.<br><b>215-50-0432</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Elaine A. Sukalo, 4701 Willard Ave.,</b>                         |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Cardio vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                                  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                  |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |  |                                  |  |   |  | TITLE (SPECIFY)<br><b>Deputy</b> M.D.   |  | DATE SIGNED <b>Feb. 23, 1979</b>  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>John G. Ball</b>  |  |                                  |  |   |  | ADDRESS <b>7936 Old Georgetown Rd., Bethesda, Md.</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                                  |  | 23b. DATE<br><b>2/26/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Trinity Cem.</b>                                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City, Md.</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph Gawler's Sons, Inc.</b><br>ADDRESS <b>5130 Wisc. Ave. N.W. Washington, D.C.</b>  |  |                                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony DeBenedictis</b>   |  |   |  |   |  |

33-010-03

1995

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |         |  |  |  |  |  |   |  |                                |  |  |  |  |  |                                      |  |                                 |  |  |  |  |  |
|---|--|---------|--|--|--|--|--|---|--|--------------------------------|--|--|--|--|--|--------------------------------------|--|---------------------------------|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |  |  |  |  |   |  |                                |  |  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN<br>OF DEATH  |  | MONTH DAY YEAR                 |  | 2b. HOUR   |  |  |  |                                      |  |                                 |  |  |  |  |  |
| WILLIAM   |  | JOHN    |  | O'BRIEN  |  | -JR.   |  | 2   |  | 3                              |  | 19 79  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                     |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE<br>PRONOUNCED<br>DEAD   |  |  |  |                                      |  |                                 |  |  |  |  |  |
| Male  |  | White   |  | Nov. 15 1919   |  | 59 YRS.  |  |   |  |                                |  | 2 3 19 79  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| Washington DC   |  |         |  | USA  |  |  |  |   |  |                                |  |  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                     |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |                                 |  |  |  |  |  |
| Silver Spring   |  |         |  | 2110 Belvedere Blvd. Apt. 2  |  |  |  |   |  |                                |  | SALESMAN - FOREMAN - LAUNDRY   |  |  |  | Apt. 2                               |  |                                 |  |  |  |  |  |
| 13a. STATE  |  |         |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN   |  |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |  |  | 13e. STREET ADDRESS                  |  |                                 |  |  |  |  |  |
| Maryland  |  |         |  | MONT. SILVER SPRING  |  |  |  |   |  |                                |  | 2110 BELVEDERE BLVD.   |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |  |   |  |                                |  | 16. SOCIAL SECURITY NO.  |  |  |  |                                      |  | 17. INFORMANT<br>ADDRESS        |  |  |  |  |  |
| William J. O'Brien - Sr   |  |         |  |  |  | Clara G. Shorter   |  |   |  |                                |  |  |  |  |  |                                      |  | Same as                         |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |         |  |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  |                                |  | 17. INFORMANT<br>ADDRESS   |  |  |  |                                      |  | Same as                         |  |  |  |  |  |
| YES   |  |         |  |  |  | W.W.II   |  |   |  |                                |  |  |  |  |  |                                      |  | VIRGINIA J. O'BRIEN - ITEMS #13 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease and<br>IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u> barbiturate intoxication<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |         |  |  |  |  |  |   |  |                                |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |                                      |  |                                 |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |         |  |  |  |  |  |   |  |                                |  |  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |  |                                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |  |  | 21b. TIME OF INJURY<br>2:41 A.M. MONTH DAY YEAR<br>A.M. 2 3 19 79      |  |   |  |                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>caught in housefire |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |         |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home |  |   |  |                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2110 Belvedere Blvd. Apt. 2 Silver Spring, Md.  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input checked="" type="checkbox"/> <del>Accident</del> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |         |  |  |  |  |  |   |  |                                |  |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                                      |  | Md.                             |  |  |  |  |  |
| ACTUAL<br>SIGNATURE   |  |         |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant                                      |  |   |  |                                |  | DATE<br>SIGNED 2/4/79  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |         |  |  |  | ADDRESS  |  |   |  |                                |  |  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| Margarita A. Korell, M.D.   |  |         |  |  |  | 111 Penn Street  |  |   |  |                                |  |  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |         |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                |  | 23d. LOCATION<br>(CITY OR TOWN) STATE  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| CREMATION   |  |         |  | 2/5/79   |  |  |  | CEDAR HILL CREM.  |  |                                |  | SUITLAND - P.G. MD.  |  |  |  |                                      |  |                                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |         |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  |                                |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                                      |  |                                 |  |  |  |  |  |
| W.W. CHAMBERS CO. SILVER SPRING MARYLAND  |  |         |  |  |  | FEB 8 1979   |  |   |  |                                |  | Morty McCreedy   |  |  |  |                                      |  |                                 |  |  |  |  |  |

40100-01

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04765  
2903481- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |   |   |  |   |  |
|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALLEN E OSTRAND</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 16, 1979</b> |  |   | 2b. HOUR<br><b>0532AM</b>   |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 11, 1930</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NATIONAL NAVAL MEDICAL CENTER</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Capt</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Navy</b>         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |   |   |  |   |  |
| 13a. STATE<br><b>VIRGINIA</b>  |  | 13b. COUNTY<br><b>Fairfax</b>   |   | 13c. CITY OR TOWN<br><b>FALLS CHURCH</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6435 WOODVILLE DRIVE</b>            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES JOSEPH OSTRAND</b>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALMA DRUSCILLA REED</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1948-1975</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MARILYN OSTRAND 6435 WOODVILLE DR</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PERITONITIS</b><br><b>1709</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Metastatic Chondrosarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 Years</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |   |  |   |   |  |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   |  |   |   |  |   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |   |  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>09 FEBRUARY 1979</b> to <b>16 FEBRUARY 1979</b> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <b>16 FEBRUARY 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did not view the body after death.  |  |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Paul M. Martell, F.R.C.P. Pathologist</b>   |  |   |   | DEGREE <b>Medical Officer</b><br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>18 Feb 79</b>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LCDR Martell, F.R.C.P. Pathologist</b>   |  |   |   | 22e. ADDRESS<br><b>NNMC BETHESDA, MD. 20014</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2-21-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARLINGTON VIRGINIA</b>                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Colonial Funeral Home</b> ADDRESS <b>FALLS CHURCH, VA</b>  |  |   |   | 25a. DATE REC'D BY REGISTRAR <b>FEB 26 1979</b><br>25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

20700-07



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |   |  | REG. NO. 79-04766 |  |
|--|--|---|--|---|---|--|--|---|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Rachel Clara Page  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 23 79 |  |  | 2b. HOUR MIN<br>7A  |  |                   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 12 88  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN  |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Brooke Grove Foundation |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |                   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Rockville  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>4203 Norbeck Rd. Rockville   |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William A Harmon  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Jane Best   |   |  |  |   |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>241-24-1911   |  | 17. INFORMANT<br>D Hilda White  |   | ADDRESS<br>Same as 13  |  |   |  |                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE<br>4409<br>DUE TO OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 YRS.<br>7 YRS.<br>7 YRS. |  |   |  |   |   |  |  |   |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>HYPERTENSIVE CVD  |  |   |  |   |   |  |  |   |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |                   |  |
| 22a. I certify that (I) [this hospital] attended the deceased from 2/6/79 to 2/23/79, that (II) (we) last saw the deceased alive on 2/23/79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) did not view the body after death.   |  |   |  |   |   |  |  |   |  |                   |  |
| 22b. SIGNATURE<br>D. R. Lewis MD   |  |   |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/23/79   |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. R. Lewis MD  |  |   |  | 22e. ADDRESS<br>OLNEY, MARYLAND 20832   |   |  |  |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2 27-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rockville Cemetery  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rockville Md.   |  |   |  |                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey<br>Homes P.A. Bethesda Maryland  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McCreedy   |  |   |  |                   |  |

12-04366

12-04366

x

x

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x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. <b>79-04767</b> |  |
|---|--|---|--|---|--|---|--|---|--|--------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |   |  |                          |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Samuel Theodore Parelman</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 28, 1979</b>                              |  | 2b. HOUR<br><b>6:35 P.M.</b>  |  |                          |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>February 11, 1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                              |  |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Clinical Center, NIH</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreign Svc. Off.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State Dept.</b>   |  |                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  |   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  |                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Morris</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Pearl</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET ADDRESS<br><b>10602 Bucknell Drive</b>          |  |   |  |   |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-42-2790</b>  |  | 17. INFORMANT<br><b>The Medical Record</b><br><b>The Clinical Center, NIH, Beth., Md</b>  |  |   |  |   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis, fungal and Bacterial</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0-5 min</b><br><b>2 months</b><br><b>4 years</b> |  |   |  |   |  |   |  |   |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |                          |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |   |  |   |  |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                          |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>22 December 1978</b> , to <b>28 February 1979</b> , that (X) (we) lost saw the deceased alive on <b>28 February 1979</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.  |  |   |  |   |  |   |  |   |  |                          |  |
| 22b. SIGNATURE<br><i>Richard E. Michalite</i>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>3/1/79</b>   |  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard E. Michalite</b>  |  | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md</b>   |  |   |  |   |  |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-4-1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l. Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Virginia</b>               |  |   |  |                          |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels</b>  |  | ADDRESS<br><b>1170 Rockville Pike</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony A. Brady</i>                                     |  |   |  |                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |         |   |  |  |  |   |  |   |  |
|--|---------|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |  |
| FIRST MIDDLE LAST  |         | MONTH DAY YEAR  |  |  |  | HOURS MIN.  |  |   |  |
| Charles M. Parkhurst   |         | 2/27/79   |  |  |  | 8:30 PM   |  |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 14 HRS   |  |
| male   | white   | MONTH DAY YEAR  |  | 75 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |
| Pa.  |         | U.S.A.  |  |  |  | montgomery MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                    |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Silver Spring  |         | Holy Cross Hospital   |  |  |  | Retired   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         | 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Ma.  |         | Ma.   |  | Silver Spring  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| Emmons M. Parkhurst  |         | Anna Rhinimiller  |  | no   |  | 139-05-3808   |  | Richard Parkhurst   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)                          |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)                                |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) |  |
| 4349   |         | MULTIPLE BILATERAL CEREBRAL   |  | INFARCTS   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | 2 WEEKS   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         | DUE TO, OR AS A CONSEQUENCE OF (b)  |  | CEREBRAL VASCULAR ACCIDENTS  |  | 2 WEEK  |  |   |  |
|  |         | DUE TO, OR AS A CONSEQUENCE OF (c)  |  | CEREBRAL ARTERIOSCLEROSIS  |  | UNCERTAIN   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |         |   |  |  |  |   |  |   |  |
| ARTERIOSCLEROTIC HEART DISEASE WITH A-V CONDUCTION DEFECT - COPD   |         |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
|  |         |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
|  |         | HOUR A.M. MONTH DAY YEAR  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION  |  |   |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |         | 22a. I certify that (I) (this hospital) attended the deceased from  |  | 22a. I certify that (I) (this hospital) attended the deceased from   |  | 22a. I certify that (I) (this hospital) attended the deceased from  |  |   |  |
| saw the deceased alive on  |         | saw the deceased alive on   |  | saw the deceased alive on  |  | saw the deceased alive on   |  |   |  |
| above, (I) (we) (did) (did not) view the body after death.   |         | above, (I) (we) (did) (did not) view the body after death.  |  | above, (I) (we) (did) (did not) view the body after death.   |  | above, (I) (we) (did) (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE   |         | 22b. SIGNATURE  |  | 22b. SIGNATURE   |  | 22b. SIGNATURE  |  |   |  |
| Lawrence A. Marcus, M.D.   |         | Lawrence A. Marcus, M.D.  |  | Lawrence A. Marcus, M.D.   |  | Lawrence A. Marcus, M.D.  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |
| LAWRENCE A. MARCUS, MD.  |         | LAWRENCE A. MARCUS, MD.   |  | LAWRENCE A. MARCUS, MD.  |  | LAWRENCE A. MARCUS, MD.   |  |   |  |
| 23a. BURIAL (SPECIFY)  |         | 23a. BURIAL (SPECIFY)   |  | 23a. BURIAL (SPECIFY)  |  | 23a. BURIAL (SPECIFY)   |  |   |  |
| CREMATION  |         | CREMATION   |  | CREMATION  |  | CREMATION   |  |   |  |
| 23b. DATE  |         | 23b. DATE   |  | 23b. DATE  |  | 23b. DATE   |  |   |  |
| 3/1/79   |         | 3/1/79  |  | 3/1/79   |  | 3/1/79  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |         | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  |
| FT. LINCOLN CEMETERY   |         | FT. LINCOLN CEMETERY  |  | FT. LINCOLN CEMETERY   |  | FT. LINCOLN CEMETERY  |  |   |  |
| 23d. LOCATION  |         | 23d. LOCATION   |  | 23d. LOCATION  |  | 23d. LOCATION   |  |   |  |
| CITY OR TOWN   |         | CITY OR TOWN  |  | CITY OR TOWN   |  | CITY OR TOWN  |  |   |  |
| PRINCE GEORGE CO. MD.  |         | PRINCE GEORGE CO. MD.   |  | PRINCE GEORGE CO. MD.  |  | PRINCE GEORGE CO. MD.   |  |   |  |
| 24. FUNERAL DIRECTOR   |         | 24. FUNERAL DIRECTOR  |  | 24. FUNERAL DIRECTOR   |  | 24. FUNERAL DIRECTOR  |  |   |  |
| Hoffman Funeral Home   |         | Hoffman Funeral Home  |  | Hoffman Funeral Home   |  | Hoffman Funeral Home  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR  |         | 25a. DATE REC'D. BY REGISTRAR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |  |
| MAR 1 1979   |         | MAR 1 1979  |  | MAR 1 1979   |  | MAR 1 1979  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE   |         | 25b. REGISTRAR'S SIGNATURE  |  | 25b. REGISTRAR'S SIGNATURE   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Rickey McCurdy   |         | Rickey McCurdy  |  | Rickey McCurdy   |  | Rickey McCurdy  |  |   |  |

86140-25

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                               |  |  |  |  |  |   |  | REG. NO. 79-04769  |  |                                 |  |
|--|--|-------------------------------|--|--|--|--|--|---|--|--|--|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harold W. Parr</b>  |  |                               |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>Feb. 1, 1979</b> |  |                                 |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>Cau</b>            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Apr. 30, 1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2b. DATE PRONOUNCED DEAD <b>Feb. 1, 1979</b>   |  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minn.</b>   |  |                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>   |  |                                 |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                               |  |  |  |  |  |   |  |  |  |                                 |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Montgomery</b> |  | 13c. CITY OR TOWN <b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>Silver Spring, Md. 1122 Tiffany Rd. 20904</b>  |  |  |  |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>William Parr</b>   |  |                               |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Henrietta Manuel</b>                        |  |   |  |  |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                               |  | 16b. SOCIAL SECURITY NO. <b>WWII 472-18-4836</b>   |  | 17. INFORMANT <b>1122 Tiffany Road</b><br><b>Rufien Parr Silver Spring, Md. 20904</b>        |  |   |  |  |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br><b>4291</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                               |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |                               |  |  |  |  |  |   |  |  |  |                                 |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                 |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |  |  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                                 |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                               |  |  |  |  |  |   |  |  |  |                                 |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |                               |  | TITLE (SPECIFY) <b>M.D.</b>  |  |  |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>Feb. 1, 1979</b> |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>  |  |                               |  | ADDRESS <b>1919 Seminary Road, Silver Spring, Md.</b>  |  |  |  |   |  |  |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |                               |  | 23b. DATE <b>Feb. 2, 79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Brentwood, Prince George, Md.</b>   |  |  |  |                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hines/Rinaldi F.H.</b>   |  |                               |  | ADDRESS <b>11800 New Hampshire Ave. Silver Spring, Md. 20904</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreary</b>   |  |                                 |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04770

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Helen Elizabeth PERKINS</i>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>FEB. 21 1979</i>  |  | 2b. HOUR <i>9:45 AM</i>   |  |
| 3. SEX<br><i>F. Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Sept. 21, 1897</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Ohio</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Colonial Villa</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <i>Maryland</i>  |  | 13b. COUNTY<br><i>Montgomery</i>  | 13c. CITY OR TOWN<br><i>Silver Spring</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>702 Venice Drive</i> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George W. Andrews</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Gertrude B. Owens</i>            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-46-3351</i>  |  | 17. INFORMANT ADDRESS<br><i>Theodore T. Perkins 702 Venice Dr. S.S. Md.</i>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i><br><i>4409</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1-2 yrs</i> |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>15 Feb</i> 19 <i>79</i> to <i>21 Feb</i> 19 <i>79</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>15 Feb</i> 19 <i>79</i> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) ( <del>not</del> ) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>William D. Aud</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>2/24/79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>William D. Aud</i>   |  | 22e. ADDRESS<br><i>9006 Colvesville Rd. Silver Spring, Md. 20910</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Feb. 26, 79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>George Washington</i>                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Adelphi, Prince George, Md.</i>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Hines/Rinaldi F.H. 11800 New Hampshire Sil.Spg. Md.</i>  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 26 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

MEDICAL CERTIFICATION

19-04770

19-04770

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04771

FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Barbara M. Pfeifer</b>                |  | 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>July</b> DAY <b>9</b> YEAR <b>1893</b>                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JAN. 16 79</b>                             |  | 2b. HOUR<br><b>3:00 PM</b>                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kethesda</b>                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Chevy Chase</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7108 Brookville Road</b>                                |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Sparr</b> LAST <b>Sparr</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>156-09-2172</b>                                       |  | 17. INFORMANT <b>Son</b> ADDRESS<br><b>Joseph W. Pfeifer. Same as item 13.</b>    |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Failure, Severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma lung, left (large) atherosclerosis, Coronary, Marked</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma, ascending colon, (Secondary Primary)</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>chronic obstructive lung disease (Carcinoma, ascending)</b>  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6</b> / <b>19</b> <b>77</b> to <b>1/16/</b> <b>19</b> <b>79</b> , that (1) (we) last saw the deceased alive on <b>1/16/</b> <b>19</b> <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (and) not view the body after death.     |  |   |  |
| 22b. SIGNATURE<br><b>Sanford N. Richman, M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/17/79.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sanford N. Richman, M.D.</b>   |  | 22e. ADDRESS<br><b>10401 Old Georgetown Rd., Beth. Md.</b>  |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>1/18/1979</b>                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b> |  | 23d. LOCATION<br>CITY <b>Silver Spring</b> COUNTY <b>Maryland</b> STATE <b>MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>JOSEPH CAWLER'S SONS INC.</b><br>ADDRESS <b>8120 WISQ. AVE., N. W. WASH., D. C. 20046</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1979</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>                |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. The first step is to identify the problem.

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CONFIDENTIAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |   |   |   |   |  | REG. NO. 79-04772   |  |
|--|--|-------------------------|--|--|---|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                         |  |  |   |   |   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joseph ALAN PHEASANT</b>   |  |                         |  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 24 19 79</b>   |   | 2b. HOUR<br>M<br><b>2:40</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT 16, 1955</b>                   |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>23</b> YRS.  |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                    |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 24 19 79</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         | 13b. COUNTY<br><b>PRI. GEORGES</b>   |  | 13c. CITY OR TOWN<br><b>ADELPHI</b>                         |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>10411 DEAKINS HALL DRIVE</b>               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX LEFFARD PHEASANT, JR.</b>   |  |                         |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PATRICIA MULLEN</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>213-66-4510</b>                               |   | 17. INFORMANT ADDRESS<br><b>MAX L. PHEASANT, JR. SAME AS 13 FATHER</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Blunt impact to head and extremities with</b><br><b>8059</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>cerebro-spinal transection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/><br>CONTRIBUTING <input type="checkbox"/>   |  |                         |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>2:04 P.M. 1 24 19 79</b>    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject run over by work train</b>                                      |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>subway</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Metro Subway, Chestnut &amp; Wisconsin Ave., Montgomery, Md.</b>                                    |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan, M.D.</b>  |  |                         |  |  |   | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER  |   |   | DATE SIGNED <b>1/25/79</b>   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |  |  |   | ADDRESS<br><b>111 Penn Street</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         | 23b. DATE<br><b>1/27/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT MD.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |                         |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey A. Cready</b>                      |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-04773  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LaVerna M. Poland</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb 21, 1979</b>                                      |  |  |  | 2b. HOUR<br><b>9:00 p.m.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6-22-1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 72 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurens Park</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>Montg. Silver Spring</b>  |  |   |  |   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13f. STREET ADDRESS<br><b>8808-Henryville Rd.</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Luther</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elia Marie Mobley</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>236-18-9010</b>   |  | 17. INFORMANT<br><b>Gary Colwell (Son)</b>   |  | 18. ADDRESS<br><b>2216 Luzerne Ave. Md.</b>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>mitral stenosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>lung cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/29/79</b> to <b>2/22/79</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Lewis Hilliard Dennis MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/22/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lewis Hilliard Dennis, M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>831 University Blvd. Suite 35 Sil. Spr. Md.</b>                           |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)<br><b>Gate of Heaven</b>   |  | 23b. DATE<br><b>2-24-1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Silver Spring Montg Co. Md</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>JAKUNA F.H. Inc. (J.A. Walters)</b>   |  |   |  | 25a. ADDRESS<br><b>254 CARRU ST. NW, Wash, D.C. 20012</b>   |  |  |  | 25b. DATE RECEIVED BY REGISTRAR<br><b>FEB 27 1979</b>  |  |  |  |

10/10/10

Dear Sir,  
I have the pleasure to inform you that  
the first shipment of your  
order has been received and is  
now in the hands of the  
warehouse. The second shipment  
will be sent out within a few  
days. I am sure you will be  
satisfied with the quality of the  
goods.

Yours faithfully,  
J. A. Williams  
General Manager

Enclosed find (1) A. Williams, General Manager, for your  
order, and (2) A. Williams, General Manager, for your  
order.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-06776

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BENJAMIN POLLACK</b>                             |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 14 79</b>   |   | 2b. HOUR<br><b>140 AM</b>  |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 15, 1891</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Austria</b>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fairland Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Laundry</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Rockville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>15321 Delphinium Lane</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leon Pollack</b>                           |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sylvia Wolfson</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |   | 16b. SOCIAL SECURITY NO.<br><b>109-28-8783</b>  |   | 17. INFORMANT<br>ADDRESS <b>Rockville, Md.</b><br><b>Louis Pollack, 15321 Delphinium Lane,</b> |   |

|  |  |  |
|--|--|--|
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b><br>DUE TO, OR AS CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>years</b><br><b>"</b> |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>June 19 75</b> to <b>2/14 79</b> , that (I) (we) last saw the deceased alive on <b>2/16 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Thos G. Ward</b>  |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/14/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thos G. Ward</b>   |  | 22e. ADDRESS<br><b>6116 Ralston Rd, Bethesda, Md.</b>                  |  |  |  |  |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-15-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Hebron Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Flushing New York</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Danzansky-Goldberg Men. Chap.</b> ADDRESS <b>1170 Rockville Pk.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1979</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Litney McCreedy</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

45540-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| Items #18a&18b<br>Film G529 3/23/79  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  | 79-04775  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Pierre Antoine Pollet sr.  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>Feb. 17 1979  |  | 2b. HOUR<br>1 AM   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Mar. 4, 13  |  | 6. AGE (In years last birthday)<br>65 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>WASH.-D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br>MONTGOMERY Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>WASHINGTON ADVENTIST-DOORMAN       |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>APT. BLDG  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>TAKOMA PARK  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>7051 CARROLL AVE                 |  |
| 14. FATHER'S NAME First Middle Last<br>BENOIT POLLET   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>HELENE MOYARD  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>579-05-0829  |  | 17. INFORMANT<br>PIERRE POLLET  |  | 11235 OAKLENE DR SILVER SPRING - MD  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) Liver Failure<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1579 <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>metastatic pancreatic cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 179, 1979, to 2/17, 1979, that (I) (we) last saw the deceased alive on 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Lewis Dennis   |  | DEGREE<br>ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22c. DATE SIGNED<br>2/18/79   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>LEWIS DENNIS   |  | 22e. ADDRESS<br>831 UNIV. BLVD. E. S.S. MD.  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>REMOVAL   |  | 23b. DATE<br>2/26/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GEORGETOWN MEDICAL SCHOOL - WASH.-D.C.  |  | 23d. LOCATION (City or Town) (County) (State)<br>WASH.-D.C.                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>W.W. CHAMBERS CO.  |  | 25a. REC'D BY REGISTRAR<br>MAR 2 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |  |  |

25740-02





79-0476

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

79-0476

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, including names and dates]

RECEIVED  
FBI  
NEW YORK  
JAN 10 1979

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |                                     |   |   |  |                     | REG. NO.<br>79-04777                         |          |  |
|---|--|--|--|--|-------------------------------------|---|---|--|---------------------|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH                   |   |   |  |                     |  | 2b. HOUR |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2b. DATE OF DEATH                   |   |   |  |                     | 2b. HOUR                                     |          |  |
| FIRST MIDDLE LAST   |  |  |  |  | MONTH DAY YEAR                      |   |   |  |                     | 2b. HOUR                                     |          |  |
| Gertrude H Post   |  |  |  |  | 2 5 79                              |   |   |  |                     | 2:39 A.M.                                    |          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | 7. IF UNDER 1 YEAR   |                     | 7. IF UNDER 74 HRS                           |          |  |
| F   |  | Caucasian  |  | MONTH DAY YEAR   |                                     | 52 YRS.   |   | MONTHS DAYS  |                     | HOURS MIN.                                   |          |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |                     |  |          |  |
| New York  |  | USA  |  |  |                                     | Montgomery MD.  |   |  |                     |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                     |  |          |  |
| Silver Spring   |  | Holy Cross Hospital  |  |  |                                     | School Teacher  |   | Mont. County   |                     |  |          |  |
| 13a. STATE  |  |  |  |  | 13b. CITY OR TOWN                   |   | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS |  |          |  |
| Maryland  |  |  |  |  | Montgomery                          |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1613 Arbor View Rd  |  |          |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME            |   |   |  |                     |  |          |  |
| FIRST MIDDLE LAST   |  |  |  |  | FIRST MIDDLE LAST                   |   |   |  |                     |  |          |  |
| Leon Berkowitz  |  |  |  |  | Esther Berkowitz                    |   |   |  |                     |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO             |   | 17. INFORMANT ADDRESS   |  |                     |  |          |  |
| No  |  |  |  |  | 133-18-2442                         |   | Silver Spring, Md.<br>Dr. Harold Post, 1613 Arbor View Rd.          |  |                     |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                                     |   |   |  |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                                     |   |   |  |                     |  |          |  |
| IMMEDIATE CAUSE (a) Irreversible Ventricular Fibrillation   |  |  |  |  |                                     |   |   |  |                     | 1 hr   |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction  |  |  |  |  |                                     |   |   |  |                     | 6 wks  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease  |  |  |  |  |                                     |   |   |  |                     |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |                                     |   |   |  |                     |  |          |  |
| Diabetes Mellitus   |  |  |  |  |                                     |   |   |  |                     |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                                     | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                     |  |          |  |
|   |  |  |  |  |                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                     |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                            |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                     |   |   |  |                     |  |          |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |                                     |   |   |  |                     |  |          |  |
|   |  | P.M. 19  |  |  |                                     |   |   |  |                     |  |          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |                                     |   |   |  |                     |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |                                     |   |   |  |                     |  |          |  |
| 22a. I certify that (1) this hospital attended the deceased from 12/30/78, to 2/5/79, that (1) was lost   |  |  |  |  |                                     |   |   |  |                     |  |          |  |
| saw the deceased alive on 1-29-79, and that in my opinion death occurred on the date and hour and from the causes stated above (or would not have seen the body after death). |  |  |  |  |                                     |   |   |  |                     |  |          |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE                              |   |   |  |                     | 22c. DATE SIGNED                             |          |  |
| Ralph E. Seligmann  |  |  |  |  | M.D.                                |   |   |  |                     | 2/5/79                                       |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS                        |   |   |  |                     |  |          |  |
| RALPH E. SELIGMANN  |  |  |  |  | 8630 FENTON ST. SIL SPR., MD. 20910 |   |   |  |                     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION   |   | 23e. REGISTERAR'S SIGNATURE                                    |                     |  |          |  |
| Burial  |  | 2-7-79   |  | Judean Mem. Gdns.  |                                     | Olney, Montgomery, Maryland   |   |  |                     |  |          |  |
| 24. FUNERAL DIRECTOR  |  | 1170 Rockville Pike  |  | 25a. DATE REC'D. BY REGISTRAR  |                                     | 25b. REGISTRAR'S SIGNATURE  |   |  |                     |  |          |  |
| NAME  |  | ADDRESS  |  | FEB 8 1979   |                                     | [Signature]   |   |  |                     |  |          |  |
| Danzansky-Goldberg Mem. Chap. Rockville, Md.  |  |  |  |  |                                     |   |   |  |                     |  |          |  |

50-0433



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 79-04779   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  | 2b. HOUR                                     |  |
| EARL C PUGH   |  |  |  |  |  |  |  | 2-10-79  |  | 7:08 AM                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS                                      |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male  |  | White  |  | Aug. 15 1886   |  | 92   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Nebraska  |  | USA  |  |  |  | Montgomery MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Silver Spring   |  | Holy Cross Hospital  |  |  |  |  |  | Retired  |  | U.S. Govt.                                   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| Maryland  |  | Montgomery   |  | Sil. Spring  |  | YES  |  | 2110 Arcola Avenue,  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Boaz F. Pugh  |  |  |  | (unknown) Cadwell  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
|   |  |  |  |  |  | Everett H. Pugh-son-Sil. Spr. Md.  |  | 8715 1st. Avenue,  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4140  |  |  |  |  |  |  |  |  |  | 30 min                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiac disease   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Retropubic prostatectomy 2/7/79   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 2/9/79  |  | Prostate Hyperplasia   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 3, 1979, to Feb 10, 1979, that (I) (we) last saw the deceased alive on Feb 9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Henry M. Wise Jr.  |  |  |  | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |  |  | 22c. DATE SIGNED 2/10/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry M. Wise Jr.   |  |  |  | 22e. ADDRESS 1111 Spring St. Sil. Spr., Md. 20910  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 2-13-79  |  | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md. |  |  |  |
| 24. NAME OF FUNERAL HOME E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 16 1979  |  |  |  | 25b. REGISTRAR'S SIGNATURE Henry M. Wise Jr.                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 79-04780   |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BEATRICE COLLEEN PYLES</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 5, 1979</b> |   |  |  |  | 2b. HOUR<br><b>10:10p</b>                          |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DECEMBER 20, 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>51</b>   |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>10:10p</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery, MD.</b>                                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CLINICAL CENTER, NIH</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |  |
| 13a. STATE<br><b>Pennsylvania</b>   |  | 13b. COUNTY<br><b>Luzerne</b>  |  | 13c. CITY OR TOWN<br><b>Berwick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1114 East 5th Street</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roy D. Guss</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Miller</b>  |  |   |  | 16. ADDRESS<br><b>1114 east 5th St.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>274-24-3354</b>   |  | 17. INFORMANT<br><b>Mr. Frank Pyles Berwick, Pa. 18603</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast Carcinoma</b><br><b>1749</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DO TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinomatosis of Bowel</b><br>DO TO, OR AS A CONSEQUENCE OF<br>(c) <b>Small and large Bowel Obstruction</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December 28, 78</b> , to <b>February 5, 1979</b> , that (I) (we) last saw the deceased alive on <b>February 5, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Thomas V. Holohan</b>  |  | DEGREE<br><b>Attending Physician</b>   |  |   |  | 22c. DATE SIGNED<br><b>2-6-79</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas V. Holohan</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/11/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zanesville Mem Park Zanesville, Ohio</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1979</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Brady</b>  |  |  |  |  |  |

79-04780

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

REPORT OF SPECIAL AGENT IN CHARGE  
TO DIRECTOR, FBI

Ohio

U.S.A.

Date

Investigator

Internal

Ref

D.

Index

File

No.

REPORT OF SPECIAL AGENT IN CHARGE  
TO DIRECTOR, FBI  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04781

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
|  |  | Thomas Earl RACINE   |  |  |  | February 12 1979   |  | 2:30 P.M.                                    |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |  |
| Male   |  | Caucasian  |  | Sept. 13 1935  |  | 43 YRS   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Alabama  |  | USA  |  |  |  | Montgomery MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Bethesda   |  | National Naval Medical Center  |  | U. S. Navy   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS                          |  |
| Maryland   |  | Washington   |  | Hagerstown   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | R.D. #1, Box 193                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                        |  |
| Woodie L. Racine   |  | Alia Mae   |  | Yes  |  | 1953-73  |  | Mary J. Racine See item 13                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)            |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)                                  |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1739   |  | Malignant Melanoma   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                       |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)         |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from Jan. 26 19 79 to Feb. 12 19 79, that (I (we) lost saw the deceased alive on Feb. 12 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE SIGNED   |  | 22g. DATE SIGNED   |  | 22h. DATE SIGNED                             |  |
| J. STEPHEN BOSTAN  |  | National Naval Medical Center, Bethesda, Md.   |  | Feb. 12, 1979  |  | Feb. 12, 1979  |  | Feb. 12, 1979                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial   |  | Feb. 13, 1979  |  | Rosehill Cemetery  |  | Hagerstown Washington Md.  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Minnick Funeral Home   |  | Hagerstown, Md.  |  | FEB 16 1979  |  | M. J. McCreedy   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79-04782  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><del>XXXXXXXX</del> Marion RAFFORD  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2/19/79  |  |   |  |
| 3. SEX<br>F   |  | 4. RACE<br>WC   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 1 89  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br>89   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>SILVERSPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home   |  |
| 13a. STATE<br>New York  |  |   |  | 13b. CITY OR TOWN<br>Hampton Bays  |  | 13c. STREET ADDRESS<br>14 Ran Pasture Road,   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Alonso Bellows   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Henrietta Burgeneister   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>157-10-7077   |  | 17. INFORMANT ADDRESS<br>XXXXXXXXXX Gladys C. Cote-daughter<br>XXXXXXXXXX (same 13)  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 1 HK<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 7 FEB 19 79 to 19 FEB 19 79, that (we) lost saw the deceased alive on 12 FEB 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Walter E. Goetz MD  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>20 FEB 79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOETZ MD   |  |   |  | 22e. ADDRESS<br>3309 SHOREFIELD RD WHEATON MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2-24-1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Grounds   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hampton Bays Suffolk N.Y.  |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc<br>8434 Ga. Ave., S.S. Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1979   |  |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 | 1489 | 1490 | 1491 |  |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO. 79-04783           |  |
|---|--|---|--|---|--|--|--|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>Harrison T. Randolph</b>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>February 24, 1979</b>  |  | 2b. HOUR <b>10:45p</b>      |  |
| 3 SEX <b>Male</b>   |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 15, 1907</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.                             |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Minister</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Methodist Church</b>  |  |                             |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Prince Geo.</b>  |  | 13c. CITY OR TOWN <b>College Park</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3602 Metzert Road</b>   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison T. Randolph Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie May Swingle</b>  |  |  |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>193 10 5514</b>   |  | 17 INFORMANT ADDRESS <b>Josephine M. Randolph Same as #13 (Wife)</b>  |  |  |  |  |  |                             |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b><br>410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Coronary Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/10/79</b><br><b>1973</b> |  |   |  |   |  |  |  |  |  |                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |                             |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2/10</b> 19 <b>79</b> to <b>2/24</b> 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>2/24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.   |  |   |  |   |  |  |  |  |  |                             |  |
| 22b. SIGNATURE <b>J. G. Lodnell</b> DEGREE <b>MD</b>  |  |   |  | 22c. DATE SIGNED <b>2/25/79</b>   |  |  |  |  |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. G. Lodnell</b>  |  |   |  | 22e. ADDRESS <b>18111 Prince Phillip Dr., Olney, Md.</b>  |  |  |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |  | 23b. DATE <b>2/28/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyattsville P.G. Md.</b>                          |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) <b>Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 01 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>   |  |                             |  |



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FOR  
STATE  
REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04784

|  |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|------------------|--|--|--|---------|--|---------|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH   |  | ESTI-<br>MATED   |  | MONTH                                      |  | DAY     |  | YEAR    |  | 2b. HOUR  |  |   |  |  |  |
| MARVIN   |  |  |  |   |  | RATCLIFFE   |  | 2  |  | 18               |  | 19   |  | 79      |  |         |  | M   |  |   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE<br>PRONOUNCED<br>DEAD             |  | MONTH   |  | DAY     |  | YEAR  |  | 2d. HOUR  |  |  |  |
| male   |  | white  |  | June 2, 1930  |  | 48 YRS.   |  |  |  |                  |  | 2  |  | 18      |  | 19      |  | 79  |  | 6:30<br>P.M.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED  |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH       |  |         |  |         |  |   |  |   |  |  |  |
| Virginia   |  | U.S.A.   |  |   |  |   |  |  |  |                  |  | Montgomery County MD.                      |  |         |  |         |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| Gaithersburg   |  | field off West Diamond Ave.  |  | Unknown   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| Maryland   |  | Montgomery   |  | Rockville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | UNKNOWN  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | FIRST  |  | MIDDLE           |  | LAST                                       |  |         |  |         |  |   |  |   |  |  |  |
| Henry C. Ratcliffe   |  |  |  |   |  | Eddie   |  |  |  |                  |  |  |  | Burgess |  |         |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| No   |  | none   |  | UNKNOWN   |  | Rebecca Neal  |  | Rt. 1 Saltville, Va.   |  | 24370            |  |  |  |         |  |         |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART I DEATH WAS CAUSED BY: Alcoholism   |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) 9010   |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last   |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| (b)  |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| (c)  |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  | 20. AUTOPSY?  |  |  |  |
|  |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 2/18/ 19 79 |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>exposed to cold |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)      |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Field off W. Diamond Ave. Gaithersburg, Md. |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |  |  |                  |  |  |  |         |  |         |  |   |  |   |  |  |  |
| ACTUAL<br>SIGNATURE  |  |  |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | MEDICAL EXAMINER   |  |                  |  | DATE<br>SIGNED                             |  |         |  | 2-21-79 |  |   |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |  |  | Margarita A. Korell, M.D.   |  |   |  | ADDRESS  |  |                  |  | 111 Penn St.                               |  |         |  |         |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |         |  |         |  |   |  |   |  |  |  |
| Burial   |  |  |  | 2/25/79   |  |   |  | Elizabeth Cemetery   |  |                  |  | Saltville Smith Va.                        |  |         |  |         |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | Loring Byers Funeral Directors, P.A.                                |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                  |  | 25b. REGISTRAR'S SIGNATURE                 |  |         |  |         |  |   |  |   |  |  |  |
| NAME ADDRESS   |  |  |  | 8728 Liberty Road Randallstown, Maryland 21133                      |  |   |  | FEB 26 1979  |  |                  |  | Loring Byers                               |  |         |  |         |  |   |  |   |  |  |  |

 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04785

|  |  |  |  |  |  |   |  |                                |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--------------------------------|--|--|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  | REG. NO. 79-04785   |  |                                |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH        |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  | 2b. HOUR                                     |  |
| Teresa   |  | V.   |  | Bodman   |  | Redmond   |  | 2/5                            |  | 1979   |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                 |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD                     |  |
| Female   |  | White  |  | Nov. 20, 1890  |  | 88 YRS.   |  | MONTHS                         |  | DAYS   |  | 2/5 1979                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 12d. HOUR                      |  | 12e. MIN   |  | 12f. P.M.                                    |  |
| Illinois   |  | USA  |  |  |  | Montgomery County   |  | 12:30                          |  | P.M.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |  |  |  |  |
| Silver Spring  |  | 240 Whitmoor Terrace   |  | housewife  |  |   |  |                                |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS            |  |  |  |  |  |
| Maryland   |  | Montgomery   |  | Silver Spring  |  |   |  | 240 Whitmoor Terrace           |  |  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                  |  | ADDRESS  |  |  |  |
| Patrick  |  | Lyons  |  | No   |  | 215-46-4385   |  | June Durkin                    |  | daughter same as 13  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART 1 DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a) Acute myocardial disease.  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4291   |  |  |  |  |  |   |  |                                |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  | None   |  |  |  |   |  |                                |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |   |  |                                |  |  |  |  |  |
| None   |  | None   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |                                |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                                |  |  |  |  |  |
|  |  | P.M. 19  |  | None   |  |   |  |                                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |                                |  |  |  |  |  |
|  |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY                         |  | STATE  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |  |  |   |  |                                |  |  |  |  |  |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |                                |  |  |  |  |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  | DATE SIGNED  |  |   |  |                                |  |  |  |  |  |
| John S. Rogers, M.D.   |  | Deputy   |  | 2/5/79   |  |   |  |                                |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |  |  |  |   |  |                                |  |  |  |  |  |
| John S. Rogers, M.D.   |  | 1919 Seminary Road   |  |  |  |   |  |                                |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN                   |  | COUNTY   |  | STATE  |  |
| Burial   |  | Feb. 8, 1979   |  | Gate of Heaven   |  | Silver Spring   |  | Mont.                          |  | Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                |  |  |  |  |  |
| Francis J. Callins   |  | FEB 9 1979   |  | [Signature]  |  |   |  |                                |  |  |  |  |  |
| 500 University Blvd. W.  |  | Silver Spring, Md.   |  |  |  |   |  |                                |  |  |  |  |  |

19-04382

RECORDS OF THE DEPARTMENT OF THE ARMY  
MEDICAL EXAMINATIONS OF PERSONNEL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |               | 79-04786                     |  |
|--|--|--|--|---|--|---|--|--|---------------|------------------------------|--|
| 1. DECEASED NAME<br>(Type or print) First Middle Last  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR<br>M |                              |  |
| Eva B. Redwine   |  |  |  |   |  | Feb. 24 1979  |  |  | 2:30 P        |                              |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>Dec. 19, 1921   |  | 6. AGE (In years last birthday)<br>57 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |               | IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign)<br>Alabama   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Montgomery  |  |  | Md.           |                              |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Washington Adv. Hospital |  | 12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.)<br>Clerk  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Storage Co. |  |               |                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>Maryland  |  | 13b. CITY OR TOWN<br>Prince Geo.   |  | 13c. CITY OR TOWN<br>Cheverly   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3115 63rd Avenue                           |               |                              |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Logan Berry  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Sally Gargis  |  |   |  |   |  |  |               |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br>423 12 9512  |  | 17. INFORMANT<br>Carroll R. Redwine Same as #13 (Husband)   |  |   |  |  |               |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Metastatic BRONCHIAL CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1830</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>40 hours</u><br><u>1 year</u> |  |  |  |   |  |   |  |  |               |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Ascites</u>  |  |  |  |   |  |   |  |  |               |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |               |                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)  |  |   |  |  |               |                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |               |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>15 Oct</u> , 19 <u>78</u> , to <u>24 Feb</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>23 Feb</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |               |                              |  |
| 22b. SIGNATURE<br><u>Thomas A. Benismor</u>  |  | 22c. DATE SIGNED<br><u>24 Feb 79</u>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |   |  |  |               |                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>THOMAS A. BENISMOR MD</u>   |  | 22e. ADDRESS<br><u>831 University Blvd E.S. 1 Spg MD 20913</u>   |  |   |  |   |  |  |               |                              |  |
| 23a. BURIAL, CREMATION, REQUIEM (Specify)  |  | 23b. DATE<br><u>2/27/79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Brentwood P.E. Md.</u>                      |  |  |               |                              |  |
| 24. FUNERAL DIRECTOR<br><u>Francis Gasch's Sons Funeral Home, P.A.</u>   |  |  |  |   |  | 25. RECEIVED BY REGISTRAR<br><u>MAR 1 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                     |               |                              |  |
| Hyattsville, Maryland  |  |  |  |   |  |   |  |  |               |                              |  |

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Small, white, bell-shaped



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of age.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-04787  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Garrett Reilly</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 01 15 79  |  |   |  |
| 3. SEX <b>MALE</b>  |  |  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR SEPT 25, 1895   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montg. Gen. Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DENTIST</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>  |  |  |  | 13b. COUNTY <b>HOWARD</b>  |  | 13c. CITY OR TOWN <b>GLENWOOD</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN PATRICK REILLY</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MURPHY</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>218-36-9931</b>  |  | 17. INFORMANT <b>SON</b> ADDRESS <b>ROCKVILLE, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Pneumonia, C.H.F., Diabetes mellitus</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 74 to Jan 15 19 79, that (I) (we) last saw the deceased alive on Jan 14 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Frederick Moomau, M.D.</b>  |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED <b>1-15-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Frederick Moomau</b>   |  |  |  | 22e. ADDRESS <b>18111 Prince Philip Dr., Olney, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>1/17/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>POPLAR SPRINGS MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Patryshal</b>   |  |

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Joseph L. Garretts Berlin

WHITE 2111 78 8-2111

WASHINGTON, D.C. 20540

Olney North. Gen. Hospital

1075 ROUTE 97

NO 2111 78 8-2111

Dr. Frederick L. 00 2111 78 8-2111

1- FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

79-04788

|  |  |  |  |   |  |                                   |  |                          |  |                        |  |                                      |  |                     |  |           |  |
|--|--|--|--|---|--|-----------------------------------|--|--------------------------|--|------------------------|--|--------------------------------------|--|---------------------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST                              |  | 26. DATE KNOWN OF DEATH  |  | MONTH                  |  | DAY                                  |  | YEAR                |  | 27. HOUR  |  |
| <i>Civil</i>   |  | <i>F</i>   |  | <i>Ricci</i>  |  |                                   |  | <i>Feb. 22 1979</i>      |  | <i>11</i>              |  | <i>58</i>                            |  | <i>N</i>            |  | <i>M</i>  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                 |  | IF UNDER 1 YR.           |  | IF UNDER 24 HRS.       |  | 2c. DATE PRONOUNCED DEAD             |  | MONTH               |  | DAY       |  |
| <i>M</i>   |  | <i>W</i>   |  | <i>OCT 5 1912</i>   |  | <i>66</i>                         |  | <i>00</i>                |  | <i>00</i>              |  | <i>Feb. 22 1979</i>                  |  | <i>11</i>           |  | <i>58</i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | XX NEVER MARRIED                  |  | WIDOWED                  |  | DIVORCED               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                     |  |           |  |
| <i>WASHINGTON, D.C.</i>  |  | <i>U.S.A.</i>  |  | <i>XX</i>   |  | <i>XX</i>                         |  | <i>XX</i>                |  | <i>XX</i>              |  | <i>Montgomery MD</i>                 |  |                     |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                          |  |                        |  |                                      |  |                     |  |           |  |
| <i>Tak Park</i>  |  | <i>Washington Hosp</i>                                   |  | <i>PEPCO</i>  |  |                                   |  |                          |  |                        |  |                                      |  |                     |  |           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS? |  | YES                    |  | NO                                   |  | 13e. STREET ADDRESS |  |           |  |
| <i>MD</i>  |  | <i>Mont</i>  |  | <i>Pt. Lpg</i>  |  | <i>YES</i>                        |  | <i>NO</i>                |  | <i>2901 Dawson Ave</i> |  |                                      |  |                     |  |           |  |
| 14. FATHER'S NAME  |  | FIRST  |  | MIDDLE  |  | LAST                              |  | 15. MOTHER'S MAIDEN NAME |  | FIRST                  |  | MIDDLE                               |  | LAST                |  |           |  |
| <i>CASIMIRRO</i>   |  |  |  |   |  | <i>RICCI</i>                      |  | <i>ALESSANDRA</i>        |  |                        |  |                                      |  | <i>DOMENICI</i>     |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                         |  | (IF YES, GIVE WAR OR DATES)                              |  | 16b. SOCIAL SECURITY NO.                                      |  | 17. INFORMANT                     |  | ADDRESS                  |  |                        |  |                                      |  |                     |  |           |  |
| <i>NO</i>  |  |  |  | <i>577-09-3105</i>  |  | <i>LENA M. RICCI</i>              |  | <i>SAME AS 13</i>        |  | <i>WIFE</i>            |  |                                      |  |                     |  |           |  |

| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|
| 4391   | IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF |   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause last.</u> | (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |   |
|  | (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                       |  |  |  |  |   |  |
|-----------------------|--|--|--|--|---|--|
| MEDICAL CERTIFICATION | 19a. DATE OF OPERATION<br><i>None</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|                       | 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
|                       | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
|                       |  |  |  |  |   |  |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) \_\_\_\_\_ DATE SIGNED Feb 23/97  
M.D. Dep. MEDICAL EXAMINER  
EXAMINER'S NAME JOHN S. ROGERS ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD  
(TYPE OR PRINT)

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>2/26/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>  | 23d. LOCATION<br>CITY OR TOWN<br><b>SILVER SPRING</b><br>COUNTY<br><b>MONT</b><br>STATE<br><b>MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>    |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1979</b><br>REGISTRAR'S SIGNATURE<br><i>Robert M. Collins</i> |   |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901                |                             |  |   |

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U.S.A.

WASHINGTON, D.C.

COMMUNIT

MESSAGING

RICCI

CASI 1960

WIFE

SAME AS 12

GENA H. RICCI

277-62-3102

JOHN S. RICCI

FRANCIS J. COLLINS

201 DWIN. AVE., SILVER SPRING, MD. 20901

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04789

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GALENA Ophrelia Ries</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-3-79</b>                      |   |   | 2b. HOUR<br><b>10<sup>30</sup> AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 22 1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Derwood</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>17408 Redland Rd.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>17408 Redland Rd.</b>                            |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Derwood</b>   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Alfred Thomas</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Mae Johnston</b>                       |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br><b>Mrs. Sterling Bogley</b>  |   | ADDRESS<br><b>17408 Redland Rd. Derwood, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>492-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Obstructive Emphysema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a), (b), or (c).<br><b>Arteriosclerotic Heart Disease, Bladder Carcinoma</b> |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-28</b> 19 <b>79</b> , saw the deceased alive on <b>1-28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>D L Bucy</b>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-3-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D L Bucy</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>809 Viers Mill Rd., Rockville Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb. 7, '79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monongahela Cemetery</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Donora Washington Pa.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Garnett Sandison</b><br><b>Gartner-Sandison F. H.</b>   |  |   |  |   | ADDRESS<br><b>916 E. Diamond Ave. Gaithersburg, Md.</b>   |  | DATE REC'D. BY REGISTRAR<br><b>FEB 8 1979</b>                              |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04790

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |  | IF UNDER 1 YEAR  |  |
| FIRST MARY   |  | FEB 15 1979  |  | IF UNDER 24 HRS  |  |
| MIDDLE ROSE  |  | 66 YRS.  |  | MONTHS DAYS HOURS MIN  |  |
| LAST RODGERS   |  | 66   |  | HOURS MIN  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                          |  |  |
| FEMALE   | WHITE  | MONTH DAY YEAR   | IF UNDER 1 YEAR  |  |  |
|  |  | MARCH 21 1912  | IF UNDER 24 HRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |  |
| WASHINGTON D.C.  | U.S.A.   |  | MONTGOMERY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| TAKOMA PARK  | WASHINGTON ADVENTIST HOSPITAL  | ASST. BUYER-KANNS  |  | DEPT STORE   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?                                 | 13e. STREET ADDRESS  |  |
| MARYLAND   | PR. GEO  | HYATTSVILLE  | YES <input type="checkbox"/> NO <input type="checkbox"/> | 7427 25th AVENUE   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST DENNIS A. MCINERNEY  |  | FIRST MIDDLE LAST ANNIE E. DONNELLY  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| NO   |  | NOT AVAILABLE  |  | NORMAN C. RODGERS, III, 9810 26th AVE ADELPHI. MD.                             |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest + Congestive Heart Failure  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Lung, brain + Liver.  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Widespread Carcinomatosis   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 2, 1960, to Feb 15, 1979, that (I) (we) lost saw the deceased alive on Feb 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| [Signature]  |  | MD   |  | 2-16-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  |
| ROBERT B. IREY   |  |  |  |  |  |
| 22e. ADDRESS   |  | 22f. DATE REC'D BY REGISTRAR   |  |  |  |
| 11161 New Hampshire Ave Silver Spring, Md  |  | FEB 25 1979  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | Feb 20 1979  |  | Mount Olivet Cemetery  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. STATE REC'D BY REGISTRAR  |  |  |  |
| Washington D.C.  |  | FEB 25 1979  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25. REGISTRAR'S SIGNATURE  |  |
| Takoma Funeral Home, 9400 Patton, 254 Canal Rd NW DC   |  |  |  | [Signature]  |  |

5801



00540-01

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MEMORANDUM FOR THE RECORD  
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04791

|  |   |  |   |  |                                   |
|--|---|--|---|--|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| PEARL JULIEN ROSEBRAUGH  |   | 2 4 79   |   | 8:43 AM  |                                   |
| 3 SEX  | 4 RACE  | 5. DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | IF UNDER 1 YEAR  |                                   |
| Female   | CAUCASIAN   | MONTH 10 DAY 29 YEAR 05  | 75  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                   |
| ILLINOIS   | USA   |  | Montgomery MD   |  |                                   |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Olney  | Montgomery General Hospital   |  | HOUSEWIFE   |  | OWN HOME                          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |   |  |                                   |
| 13a STATE  | 13b COUNTY  | 13c CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e STREET ADDRESS   |                                   |
| MARYLAND   | MONT-   | SILVER SPRING  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3559 LEISUR WORLD DR   |                                   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| JOHN AUGUST JULIEN   |   | IDA C. ANDERSON  |   |  |                                   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b SOCIAL SECURITY NO.  |   | 17 INFORMANT   |                                   |
| NO   |   | 178-32-7642  |   | DIANE KLEIN - GARRETT PK. - MD.  |                                   |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  |   |  |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:   |   |  |   |  |                                   |
| IMMEDIATE CAUSE (a) Bronchogenic carcinoma   |   |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) metastases.   |   |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |   |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |  |                                   |
| Coronary artery disease & remote myocardial infarction   |   |  |   |  |                                   |
| 19a DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22a. I certify that (I) (the hospital) attended the deceased from 20 Feb 19 76, to 4 Feb 19 79, that (I) (we) last saw the deceased alive on 4 Feb 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br>Gustavo S. Belaval MD  |   | 22c. DATE SIGNED<br>4 Feb 79   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gustavo S. Belaval  |   | 22e. ADDRESS<br>Leisure world Medical Center<br>Silver Spring MD 20906   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| CREMATION  |   | 2/5/79   |   | CEDAR HILL CREM.   |                                   |
| 24. FUNERAL DIRECTOR<br>(NAME)   |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
| W.W. CHAMBERS CO. MARYLAND   |   | FEB 8 1979   |   | [Signature]  |                                   |

10540-05

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 79-04792 |  |
|--|--|--|--|---|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Helena W Sadowski  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 3 79   |  | 2b. HOUR<br>12 AM  |  |          |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 19 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br>Maryland  |  |  |  |   |  | 13c. COUNTY<br>Montgomery  |  | 13d. CITY OR TOWN<br>Rockville   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Stanislaw Calak   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Wladyslawa Sandowski                   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>216 74 3367  |  | 17. INFORMANT ADDRESS<br>Alexander F. X Sadowski Same as item 13   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BLAST CRISIS</u><br>2051 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC MYELOGENOUS LEUKEMIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC MYELOGENOUS LEUKEMIA</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 WEEKS</u><br><u>18 MONTHS</u> |  |  |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes mellitus - Blindness - Hypertension</u>   |  |  |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>77</u> to <u>Sept</u> 19 <u>78</u> , that (I) (we) lost saw the deceased alive on <u>Sept</u> 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br>Eugene P. Libe MD  |  |  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EUGENE P. LIBE MD   |  |  |  |   |  | 22e. ADDRESS<br>10400 CONNECTICUT AVE KENNESAW MD. 20785                             |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-9-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St Stanislaw Church   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Pine Island New York                      |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Md. 20852  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 7 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |          |  |

BP

12-04725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |  |   |  |  |
|--|--|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |  | 79-04793<br>REG. NO.  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>William F. SAMPSELLE</b>   |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2. 7. 79   |  |   |  |  |
| 3. SEX <b>M Male</b>   |  |   |   |  | 2b. HOUR 8:25 PM  |  |   |  |  |
| 4. RACE <b>White W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR Nov 5, 1896   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter Ret.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>   |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |   | 13c. CITY OR TOWN <b>Takoma Park</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Lee H. Sampselle</b>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Wynkoop</b>                   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  |   | 16b. SOCIAL SECURITY NO. <b>577-24-1187</b> |  | 17. INFORMANT ADDRESS <b>Gladys D. Sampselle, (wife) same as above</b>            |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACIDOSIS</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PULMONARY EMBOLUS ?</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____               |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b><br><b>1 DAY</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CARCINOMA OF STOMACH &amp; METASTASES; INANITION</b>  |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION <b>1-29-79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF STOMACH</b>  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-28-</b> 19 <b>79</b> , to <b>2-7</b> 19 <b>79</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>2-7</b> 19 <b>79</b> , and that in (my) ( <del>the</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>did not</del> ) (did not) view the body after death. |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE <b>Dwight R. Smith, M.D.</b> DEGREE <b>M.D.</b>   |  |   |   |  | 22c. DATE SIGNED <b>2-8-79</b>  |  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SMITH, DWIGHT R.</b>                |  |
| 22e. ADDRESS <b>800 PERSHING DR. SILVER SPRING, MD</b>   |  |   |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>2/9/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo's Md.</b>                       |   |  |  |
| 24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCready</b>  |  |  |

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*Journal of Interpersonal Violence*

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Items #18a-22a Film G530 4/3/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04794  
REG. NO.

|  |         |  |  |   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
|--|---------|--|--|---|--|---|--|-------------------------------|--|--------------------------------|--|----------------------------|--|------------------|--|-------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH    |  | 2b. DATE<br>ESTI-<br>MATED     |  | MONTH                      |  | DAY              |  | YEAR  |  | 2c. HOUR |  |
| Montine  |         |  |  |   |  | Sanders   |  |                               |  |                                |  | 2                          |  | 28               |  | 19 79 |  | M        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.              |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH                      |  | DAY              |  | YEAR  |  | 2d. HOUR |  |
| Female   | Black   | 8 8 21   |  | 57 YRS.   |  |   |  |                               |  |                                |  | 2                          |  | 28               |  | 19 79 |  | 3:49 P M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| S. C.  |         | USA  |  |   |  | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                   |  | Montgomery County,            |  |                                |  |                            |  |                  |  |       |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| Bethesda   |         | Suburban Hospital  |  | Domestic  |  | None  |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS           |  |                                |  |                            |  |                  |  |       |  |          |  |
|  |         |  |  |   |  |   |  | 310 14th Street, N.E.         |  |                                |  |                            |  |                  |  |       |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| Miles Staggs   |         | Pauline Austin   |  |   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| Unk  |         | 578-50-6017  |  | Eddie Sanders, Jr./son/4068 Warner Ave.   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:  |         | 4178   |  | #D-3, Landover Hills, Md.   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| IMMEDIATE CAUSE (a)  |         | Hemoptysis secondary to ruptured arteriovenous   |  | malformation of the lung  |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |         | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
|  |         | (c)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                            |         |  |  |   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on  |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| ACTUAL<br>SIGNATURE  |         | Virginia L. Dolan  |  | TITLE (SPECIFY)<br>Assistant  |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED                |  | 3/1/79                         |  |                            |  |                  |  |       |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | Virginia L. Dolan, M.D.  |  | ADDRESS   |  | 111 Penn Street   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| Burial   |         | 3-6-79   |  | Harmony Memorial Park   |  | Landover, Md.   |  |                               |  |                                |  |                            |  |                  |  |       |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | John T. Rhines Co.,  |  | ADDRESS   |  | 3015 12th St., N.E., D. C.  |  | 25a. DATE REC'D. BY REGISTRAR |  | MAR 8 1979                     |  | 25b. REGISTRAR'S SIGNATURE |  | Anthony McCreedy |  |       |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

40240-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                      |  | 79-04795           |     |           |          |
|--|--|--|--|--|--|---|--|----------------------|--|--------------------|-----|-----------|----------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |                      |  |                    |     |           |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST <b>FRED</b>  |  | MIDDLE <b>R</b>  |  | LAST <b>SANDERSON</b>   |  | 2a. DATE OF DEATH    |  | MONTH              | DAY | YEAR      | 2b. HOUR |
|  |  | 7 Fred   |  | R  |  | Sander son  |  | 6 2                  |  | 11                 | 79  | 11        | 3 PM     |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR      |  | IF UNDER 24 HRS    |     |           |          |
| Male   |  | White  |  | June 5 1893  |  | 85 YRS.   |  | MONTHS               |  | DAYS               |     | HOURS MIN |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                      |  |                    |     |           |          |
| D.C.   |  | U.S.A.   |  |  |  | Montgomery  |  |                      |  |                    |     | MD.       |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                      |  |                    |     |           |          |
| Chevy Chase  |  | Bethesda Retirement & Nurseing Cen.  |  | Physician (ret)  |  | Medicine  |  |                      |  |                    |     |           |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                    |     |           |          |
| Maryland   |  | Montgomery   |  | Chevy Chase  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  | 5501 Chamberlin Ave. |  |                    |     |           |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                      |  |                    |     |           |          |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |                      |  |                    |     |           |          |
| John M. Sanderson  |  | Alice Oulahan  |  |  |  |   |  |                      |  |                    |     |           |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                      |  |                    |     |           |          |
| No   |  | 220-44-4038  |  | Daughter   |  | Kensington, Md.   |  |                      |  |                    |     |           |          |
|  |  |  |  | Mrs. Robert W. McChesney   |  | 4214 Dunnell Lane   |  |                      |  |                    |     |           |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |                      |  |                    |     |           |          |
| PART 1. DEATH WAS CAUSED BY:   |  | 10 hr  |  |  |  |   |  |                      |  |                    |     |           |          |
| IMMEDIATE CAUSE (a)  |  | 10 yr  |  |  |  |   |  |                      |  |                    |     |           |          |
| 492- Congestive Heart Failure  |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| (b) Emphysema  |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| (c)  |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                |  |                      |  |                    |     |           |          |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |                      |  |                    |     |           |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                      |  |                    |     |           |          |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                      |  |                    |     |           |          |
|  |  | P.M. 19  |  |  |  |   |  |                      |  |                    |     |           |          |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY               |  | STATE              |     |           |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  | STREET   |  |   |  |                      |  |                    |     |           |          |
| 22a. I certify that (I) (the hospital) attended the deceased from  |  | 19 65  |  | to   |  | 2/11  |  | 19 79                |  | that (I) (we) lost |     |           |          |
| now the deceased alive on  |  | 2/11/79  |  | 19 79  |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |                      |  |                    |     |           |          |
| above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |                      |  |                    |     |           |          |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                      |  |                    |     |           |          |
| Joseph J. Wallace  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 2/12/79  |  |   |  |                      |  |                    |     |           |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                      |  |                    |     |           |          |
| Joseph J. Wallace, M.D.  |  | 5272 River Rd., Bethesda, Maryland.  |  |  |  |   |  |                      |  |                    |     |           |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN         |  | COUNTY             |     | STATE     |          |
| Burial   |  | 2/15/1979  |  | Gate of Heaven Cemetery  |  | Silver Spring   |  |                      |  |                    |     | Maryland. |          |
| 24. FUNERAL DIRECTOR NAME  |  | JOSEPH GAWLER'S SONS INC.  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                      |  |                    |     |           |          |
|  |  | 8130 WISC. AVE., N. W. WASH., D. C. 20016  |  | FEB 16 1979  |  | [Signature]   |  |                      |  |                    |     |           |          |

2/22/79 Date of Heaven Cemetery Silver Spring, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO. 79-04796   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Charles D. Sanger   |  |  |  |   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>02-15-79                                      |  | 2b. HOUR<br>9 <sup>30</sup> P. M.         |  |
| 3. SEX<br>Male  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug 6 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                            |  |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>bus operator   |  |   |  |   |  |
| 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington   |  |  |  |   |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3201 Geiger Street |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Samuel Sanger  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rebecca Bowman  |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>--   |  | 17. INFORMANT<br>Virginia Miller same as 13e  |  |   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Burkitt Lymphoma</u><br>2002 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>months</u> |  |  |  |   |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Congestive Heart Failure</u>   |  |  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> 19 <u>79</u> , to <u>2/16</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Joel Schalm</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Joel Schalm</u>   |  |  |  | 22e. ADDRESS<br><u>9410 Old Georgetown Rd Bethesda</u>  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/19/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Brentwood, Maryland                    |  |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Md. 20852   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1979                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barney McCurdy</u>   |  |   |  |   |  |

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72-0436



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |  |   |                            |  |
|---|--|---|--|--|---|--|--|---|----------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 79-04797  |  |  |   |  |  |   |                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Florence L. Sarker  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 7 79                    |  | 2b. HOUR<br>12 noon  |   |                            |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 12 1879   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                       |  |   |                            |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br>MD.  |  | 13c. COUNTY<br>MONT.  |  | 13d. CITY OR TOWN<br>GAITHERSBURG  |   | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13f. STREET ADDRESS<br>201 Russell Dr.  |                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William E. LUTHER  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CATHERINE STONE |  |  |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>-   |  | 17. INFORMANT ADDRESS<br>CATHERINE S. WATNEY CULVER MILITARY ACADEMY CULVER, IND. 46511  |   |  |  |   |                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 CONGESTIVE HEART FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC FAILURE<br>(c) ARTERIOSCLEROSIS<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) SENILE LITZ |  |   |  |  |   |  |  |   |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5/79 to 2/7/79, that (I) (we) lost above (a) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |  |   |  |  |   |                            |  |
| 22b. SIGNATURE<br>Thos G. Ward  |  |   |  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/7/79 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thos G. WARD   |  |   |  |  | 22e. ADDRESS<br>6116 Robinwood Bethesda MD                    |  |  |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2/11/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR BLUFF  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Annapolis AA MD                                   |  |   |                            |  |
| 24. FUNERAL DIRECTOR NAME<br>John M. Taylor Sons Annapolis MD   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 12 1979                  |  | 25b. REGISTRAR'S SIGNATURE<br>Loring McBrady   |   |                            |  |



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure, but the specific words and numbers are too light to transcribe accurately.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-04798  
REG. NO.FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Antoinette N Sartwell</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>3</b> YEAR <b>79</b>  |  | 2b. HOUR<br><b>1 A M</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 4. RACE<br><b>Wh.</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>13</b> YEAR <b>28</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. STREET ADDRESS<br><b>Rockville</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Frank</b> MIDDLE <b>Napoli</b> LAST <b>Genovese</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Josephine</b> MIDDLE <b>Genovese</b> LAST <b>Genovese</b>                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>577-34-1373</b>  |  | 17. INFORMANT<br><b>husband</b> ADDRESS<br><b>Wilbur R. Sartwell same as 13</b>      |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Colon Carcinoma Primary</b><br>9 months<br>(c) <b>9 months</b> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2/1</b> 19 <b>79</b> , to <b>2/3</b> 19 <b>79</b> , that (we) lost saw the deceased alive on <b>2/3</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did not see the body after death.       |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Edward Mehlman, M.D.</b>   |  | DEGREE<br><b>M.D. FCCP</b>   |  | 22c. DATE SIGNED<br><b>2/3/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Mehlman</b>   |  | 22e. ADDRESS<br><b>8218 Wisconsin Avenue Bethesda, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 6, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>                          |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Silver Spring</b>   |  | COUNTY<br><b>Mont.</b>   |  | STATE<br><b>Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis J. Collins</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Rickey McCreedy</b>                                 |  |
| 500 University Blvd., W. Silver Spring, Md.   |  |  |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10-04198

Washington, D.C.  
Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
U.S. Department of Justice  
Washington, D.C.  
Dear Mr. Hoover:

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.  
Very truly yours,  
John Edgar Hoover  
Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO.<br>79-04799 |
|---|--|--|--|---|--|---|--|--|--|----------------------|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BENJAMIN WILLIAM Schneider  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 10 79   |  | 2b. HOUR<br>9:24 P.M.  |  |                      |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>January 15, 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Latvia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Cherry Chase Nursing & Convalescent Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Merchant                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Jewelry   |  |                      |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>8811 Colesville Road, #517  |  |                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Not Known  |  |   |  |   |  |  |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW-1   |  | 17. INFORMANT<br>Harold Schneider   |  | ADDRESS<br>341 Kings Highway West<br>Haddonfield, New Jersey                                    |  |  |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 DAY<br>5 HRS |  |  |  |   |  |   |  |  |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |  |  |                      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                      |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-15-1958, to 2/10/79, 19_____, that (I) (we) lost saw the deceased alive on 2/10/79, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |                      |
| 22b. SIGNATURE<br>James H. Ribbens  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>2/10/79   |  |  |  |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br>1145-19TH ST NW WASHINGTON DC  |  |   |  |   |  |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/12/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King David Memorial Garden  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Falls Church, Virginia                               |  |  |  |                      |
| 24. FUNERAL DIRECTOR NAME<br>Donald M. Stein  |  | 24b. DATE REC'D. BY REGISTRAR<br>FEB 14 1979   |  | 24c. NAME OF CEMETERY OR CREMATORY<br>Hebrew Memorial F.H.  |  | 24d. ADDRESS<br>232 Carroll Street, N. W. Washington, D. C.                                     |  | 24e. SIGNATURE<br>[Signature]  |  |                      |

BP

90140-05

4-12-74

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <b>Mildred Charlotte Schulze</b>  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Mildred Charlotte Schulze</b>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>5</b> YEAR <b>79</b>                                 |  | 2b. HOUR <b>12</b> P.M.   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH <b>Oct</b> DAY <b>14</b> YEAR <b>1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>  |  | 7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>                           |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>9005 Quintana Dr.</b>  |  |
| 14. FATHER'S NAME FIRST <b>Joe</b> MIDDLE <b>Kolb</b> LAST <b>Kolb</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Vierbuchen</b> LAST <b>Vierbuchen</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  | 17. INFORMANT ADDRESS <b>20034 Hugo Schulze-son 9005 Quintana Dr. Bethesda, Md.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)   |  |   |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bleeding from ulcerated melanoma</b>  |  |   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse metastatic melanoma</b>  |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe lymphedema</b>  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:40</b> P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-14-79</b> to <b>2-5-79</b> , that (I) (we) last saw the deceased alive on <b>2-4-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>H. B. Brown</b>  |  |   |  | DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>2-5-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>2-6-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>  |  | 23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY STATE                              |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b> ADDRESS <b>300-4th St. N.E. 20002 Wash. D.C.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Mary M. Brady</b>  |  |   |  |

00840-27

THE UNITED STATES OF AMERICA

IN SENATE

January 10, 1940

REPORT

OF THE

COMMISSIONER OF

THE

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OFFICE

ON THE

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U.S. GOVERNMENT

PRINTING OFFICE

WASHINGTON

1940

U.S. GOVERNMENT PRINTING OFFICE: 1940



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 79-04801  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR   |  |  |  |
| Earl K. Scott   |  |  |  | 2/17/79 12:40am  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.                           |  |
| Male  |  | White  |  | May 21 1908  |  | 70   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Wash., D C.   |  | U.S.A.   |  |  |  | Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Silver Spring   |  | 410 Gilmore Dr.  |  | Printing Pressman  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |  |  | 13e. STREET ADDRESS  |  |  |  |
| Md. Montgomery Silver Spring  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> 410 Gilmore Dr.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| Clyde Scott   |  |  |  | Elsie Keithley   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| no  |  | 578-01-4416  |  | Marguertie V. Scott Same as #13  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Myeloma<br>2030 } DUE TO, OR AS A CONSEQUENCE OF (b) }<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) } |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (X) (did not) attended the deceased from 12/20 19 77, to 2/16 19 79, that (I) (X) last saw the deceased alive on 2/16 19 79, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did) (did not) view the body after death.                                |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Herbert J. Alpert   |  |  |  | M.D.   |  | 2/17/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| Herbert J. Alpert   |  |  |  | Silver Spring, Maryland  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Cremation   |  | 2-17-79  |  | Metropolitan Crematory   |  | Alexandria, Va.  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Francis J. Collins  |  |  |  | FEB 22 1979  |  | Dorothy McCreedy   |  |
| 500 University Blvd. W., Silver Spring, Md.   |  |  |  |  |  |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04802

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |  |                                   |  |  |
|--|--|---|---|---|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WARREN E. SCOTT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>26</b> YEAR <b>1979</b> |   |  | 2b. HOUR<br><b>9:AM</b>   |  |  |                                   |  |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>20</b> YEAR <b>1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 years</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |                                   | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Washington, D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>N/A Mont</b>   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>1220 East-West Highway #205</b> |   |   |  | 12a. USUAL OCCUPATION<br><b>Policeman (Ret.)</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |  |   |  |  |                                   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET ADDRESS<br><b>1220 East-West Highway #205</b>  |                                   |  |  |
| 14. FATHER'S NAME<br><b>William E. Scott</b>   |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME<br><b>Victoria Parry</b>   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>579-52-7013A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary C. Scott (Wife) 1220 East-West Highway</b>                            |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>2028</b><br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LYMPHOMA LIVER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>60 days</b>   |  |   |   |   |  |   |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>D. ABILITY RELATIVE TO DEATH BY ACCIDENTAL SCISSORS</b>   |  |   |   |   |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>                |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>  |  | 21f. LOCATION<br>STREET <b>630 AM</b> CITY OR TOWN <b>630 AM</b> COUNTY <b>630 AM</b> STATE <b>630 AM</b> |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 55</b> to <b>FEB 26</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br><b>11/17/79 M. Rose</b>  |  |   |   | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>2/26/1979</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Morton H. Rose, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>916 19th. Street, N.W. #514</b>  |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-2-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Mem. Cemeter. Suitland, P. G. Md.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>SUITLAND</b> COUNTY <b>PRINCE GEORGES</b> STATE <b>MARYLAND</b>          |  | 24. FUNERAL DIRECTOR<br><b>W. Ernest James Co., Inc. 1132 You Street, N.W. MAR 8 1979</b>  |                                   |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |                  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                      |   |  |  | REG NO. 79-04803  |  |   |  |
|--|------------------|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert Lawrence Scruggs</b>   |                  |  |   |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Feb. 17, 1979</b> |  |   |  |
| 3. SEX <b>M</b>  | 4. RACE <b>B</b> | 5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 25 31 47</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN <b>31 47</b> | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD <b>Feb. 24, 1979</b>   |  | 2d. HOUR <b>3:00 PM</b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>St. Louis</b>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3305 Niles St</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>N.I.H.</b> |  |
| 13a. STATE <b>Mo</b>   |                  | 13b. COUNTY <b>Mont</b>  |   | 13c. CITY OR TOWN <b>St. Louis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 13e. STREET ADDRESS <b>3305 Niles St</b>        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Eugene Scruggs</b>   |                  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie A. Olds</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>   |                  | 16b. SOCIAL SECURITY NO. <b>none</b>   |   | 17. INFORMANT <b>unobtainable</b>  |  | ADDRESS <b>Memphis</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute and Chronic Alcoholism</b><br>303-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |                  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |                  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |  |   |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |                  | TITLE (SPECIFY) <b>DME</b>   |   |  |  | MEDICAL EXAMINER  |  | DATE SIGNED <b>Feb. 24/1979</b>                 |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>   |                  | ADDRESS <b>1919 Seminary Road, S. S. Md.</b>   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                  | 23b. DATE <b>3-2-1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>New Park Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Memphis Tenn.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>   |                  | ADDRESS <b>8434 Ga. Ave., S.S. Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 01 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Petry McCreary</b>  |  |   |  |

100-100-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 79-04804  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|-----------------------------|--|-----------------------------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2-6-79  |  |  |  |  |  |  | 2b. HOUR 730 AM                              |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUTHER C. SEDBERRY   |  |  |  |  | 3 SEX M  |  |  |  |  | 4 RACE W   |  | 5. DATE OF BIRTH MONTH DAY YEAR July 22 1906 |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |                             |  |                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Takoma Park   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Printing Firm   |  |                             |  |                             |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 13a. STATE Maryland   |  |  |  |  | 13b. COUNTY Montgomery   |  |  |  |  | 13c. CITY OR TOWN Takoma Park  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |                             |  |                             | 13e. STREET ADDRESS 400 Browning Avenue, |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST James H. Sedberry   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Stanton  |  |  |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  |  |  |  | 16b. SOCIAL SECURITY NO. none  |  |  |  |  | 17. INFORMANT Lora H. Sedberry-wife-(same as 13e)  |  |  |  |  | ADDRESS   |  |                             |  |                             |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Respiratory failure<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) atherosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertension     |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  | Cerebro-vascular accident  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |                             |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 22a.1 certify that (I) (this hospital) attended the deceased from 12-28-78 to 2-6-79, that (I) (we) lost saw the deceased alive on 2-5-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 22b. SIGNATURE M Snow MD  |  |  |  |  | DEGREE   |  |  |  |  | 22c. DATE SIGNED 2-6-79  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M SNOW MD   |  |  |  |  | 22e. ADDRESS 9013 FLOWER AVE SILVER SPRING MD  |  |  |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  |  | 23b. DATE Feb. 9-79  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Md.   |  |                             |  |                             |  |  |  |  |  |
| 24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.   |  |  |  |  | ADDRESS 8434 Ga. Ave., S.S. Md.  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 13 1979  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Anthony McCready   |  |                             |  |                             |  |  |  |  |  |



79-04804

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

|  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
|--|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1  | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
| [Faint, mostly illegible text and markings throughout the form grid] |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04805

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harry S. Selyianes</b>  |  | 2a. DATE OF DEATH<br><b>February 1, 1979</b>   |  | 2b. HOUR<br><b>6:05 PM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Jan. 17, 1927</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Buffalo N.Y.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOTIFY SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b>           |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Ret. Mgr.</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS<br><b>141-1st Avenue N.W. Natick, Mass.</b>  |  | 13b. CITY OR TOWN<br><b>Natick</b>   |  |
| 13c. COUNTY<br><b>Mass.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>141-1st Avenue Natick, Mass.</b>                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stalio's</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fachio</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>559-38-3317</b>  |  | 17. INFORMANT<br><b>Emanuel Selyianes</b>  |  | 18. ADDRESS<br><b>13e</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain metastases, invasion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Branchogenic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 months</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1979</b> to <b>Feb 1, 1979</b> , that (I) (we) saw the deceased alive on <b>Feb 1, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | 22c. DATE SIGNED<br><b>2/1/79</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DJ HADAK</b>                         |  |
| 22e. ADDRESS<br><b>6525 Belvoir Rd Natick, Mass.</b>  |  | 22f. DATE SIGNED<br><b>2/1/79</b>  |  | 22g. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DJ HADAK</b>                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Feb 5-1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Lucian Crematory</b>                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington D.C.</b>  |  | 23e. DATE RECD. BY REGISTRAR<br><b>FEB 6 1979</b>  |  | 23f. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.A. Walters, Takoma F.H. Inc. Wash, D.C. 20012</b>  |  |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |  |                  |  |  |   |  | REG. NO. 78-04806                            |  |
|--|------------------|--|--|--|------------------|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |                  |  |  |  |                  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Ruth Livingston Shivers</i>  |                  |  |  |  |                  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <i>Feb 28, 1979</i>                |  | 2b. HOUR <i>3:45 AM</i>   |  |  |  |
| 3. SEX <i>F</i>  | 4. RACE <i>W</i> | 5. DATE OF BIRTH MONTH <i>Dec</i> DAY <i>17</i> YEAR <i>1928</i>   | 6. AGE (IN YEARS) LAST BIRTHDAY <i>51</i> YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD <i>Feb 28, 1979</i>   |  | 2d. HOUR <i>3:45 AM</i>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW JERSEY</i>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Althea Woodland Nur. Home</i> |  |  |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE <i>MD</i>   |                  | 13b. COUNTY <i>Mont</i>  |  | 13c. CITY OR TOWN <i>Silver Spring</i>   |                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 13e. STREET ADDRESS <i>4408 WESTBROOK LANE</i>  |  | <i>Art</i>                                   |  |
| 14. FATHER'S NAME FIRST <i>ELWELL</i> MIDDLE <i>R.</i> LAST <i>WARRINGTON</i>  |                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <i>ANNIE</i> MIDDLE <i>D.</i> LAST <i>LONG</i>  |                  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>   |                  |  |  | 16b. SOCIAL SECURITY NO. <i>155-36-9481</i>  |                  | 17. INFORMANT <i>GRANDSON</i>  |  | ADDRESS <i>17614 KOHLHOSS ROAD POOLESVILLE, MD.</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Anterior-cerebral Cordic Vessel</i><br><i>4049</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <i>Renal Dis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Yrs</i>                                     |                  |  |  |  |                  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>Fracture Rt. Hip</i>   |                  |  |  |  |                  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION <i>Sept. 27, 1978</i>   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture Rt. Hip</i>  |                  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                  |  |  | 21b. TIME OF INJURY HOUR <i>9:25</i> AM. MONTH <i>12</i> DAY <i>28</i> YEAR <i>1978</i> P.M.   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fell in living room</i> |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Nursing Home Delview Dr. Silver Spring</i>  |                  | 21f. LOCATION STREET <i>Mont</i> CITY OR TOWN <i>MD</i> COUNTY <i>MD</i> STATE <i>MD</i>                 |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |  |                  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i>   |                  |  |  | TITLE (SPECIFY) <i>M.D.</i>  |                  |  |  | MEDICAL EXAMINER  |  | DATE SIGNED <i>Feb 28, 1979</i>              |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>  |                  |  |  | ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>  |                  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>  |                  | 23b. DATE <i>3/3/79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>LAKEVIEW MEMORIAL PARK</i>   |                  |  |  | 23d. LOCATION CITY OR TOWN <i>MOORESTOWN</i> COUNTY <i>NEW JERSEY</i> STATE <i>NEW JERSEY</i> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>  |                  |  |  |  |                  | 25a. DATE REC'D. BY REGISTRAR <i>MAR 2 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Patricia McBrady</i>  |  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |                  |  |  |  |                  |  |  |   |  |  |  |

79-04806

500 UNIV. BLVD., W. SILVER SPRING, MD. 20901

LAKEVIEW MEMORIAL PARK MORE

NEW JERSEY

JOHN C. ROGERS

1719 SEAVIEW ROAD SILVER SPRING, MD.

FRANCIS J. COLLINS  
2/3/79

BURIAL

NO 1  
ELWELL  
HARRINGTON  
GRANDSON  
LAWRENCE W. BURKE  
PROCESSED  
1774  
HOUSELIFE  
WASHINGTON  
KIDNAPING  
2000 WESTBROOK LAKE  
WYOMING



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |  |  |                                    |  |  |   |   | 79-04807                                     |                             |  |
|---|--|------------------------------|--|--|------------------------------------|--|--|---|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR  |  |                              | REG. NO.   |  |                                    |  |  |   |   |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                              | FIRST MIDDLE LAST  |  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   | 2b. HOUR MIN.   |  |                             |  |
| William August Silverwood   |  |                              |  |  |                                    | JAN 1 1979   |  |   | 6 A M   |  |                             |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH MONTH DAY YEAR  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |  |
| male  |  | white                        |  | JAN 9 1892   |                                    | 86 YRS.  |  |   |   |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |   |  |                             |  |
| Maryland  |  | USA                          |  |  |                                    | Montgomery MD.   |  |   |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                             |  |
| Gaithersburg  |  |                              | Herman Health Care Center Russell Ave  |  |                                    | Inspector  |  |   | Insurance   |  |                             |  |
| 13a. STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS   |  |                             |  |
| MD  |  |                              | Baltimore  |  | Baltimore                          |  |  |   | 1632 N. Calvert St.   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |                              | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |                                    |  |  |   |   |  |                             |  |
| John W. Silverwood  |  |                              | Caroline C. Littermole   |  |                                    |  |  |   |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS              |  |  |   |   |  |                             |  |
|   |  |                              | 212-07-0536  |  | Nursing Home Record 3              |  |  |   |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 411 - <u>Acute Coronary Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular insuff. - Arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Arteriosclerosis</u> |  |                              |  |  |                                    |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |  |
|   |  |                              |  |  |                                    |  |  |   |   | 1 DAY  |                             |  |
|   |  |                              |  |  |                                    |  |  |   |   | 20 YRS                                       |                             |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |  |                             |  |
|   |  |                              | P.M. 19  |  |                                    |  |  |   |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |                             |  |
|   |  |                              |  |  |                                    |  |  |   |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28/78, 1978, to 1/1/79, 1979, that (I) (we) lost saw the deceased alive on 12/28/78, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |                              |  |  |                                    |  |  |   |   |  |                             |  |
| 22b. SIGNATURE  |  |                              | DEGREE   |  |                                    | 22c. DATE SIGNED   |  |   |   |  |                             |  |
| Henry C. Scruggs MD   |  |                              |  |  |                                    | 1/1/79   |  |   |   |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              | 22e. ADDRESS   |  |                                    |  |  |   |   |  |                             |  |
| Henry C. Scruggs MD   |  |                              | 5413 Cedar Lane Bethesda Md.   |  |                                    |  |  |   |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |  |                             |  |
| Burial  |  |                              | Jan. 3, 1979   |  | Lorraine Park Cemetery             |  |  | Baltimore Balt. Maryland                |   |  |                             |  |
| 24. FUNERAL DIRECTOR NAME   |  |                              | 24b. ADDRESS   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE  |  |                             |  |
| Gardner Sandison  |  |                              | 316 E. Diamond Avenue Gaithersburg, Md.  |  |                                    | JAN 5 1979   |  |   |   |  |                             |  |

70340-25



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04808  
REG. NO.

|  |                         |  |  |   |  |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Richard M. Simpson</b>  |                         | 2. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>Feb 14 1979</b>   |  | 2a. HOUR <b>7:58</b>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>March</b> DAY <b>6</b> YEAR <b>1902</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>76</b> RS. | 7. IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  | 7b. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZENSHIP WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sping</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>   |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY<br><b>Mont</b>   |  | 13c. CITY OR TOWN<br><b>Sping</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>C</b> LAST <b>Simpson</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>M</b> LAST <b>Mitchell</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>577-78-0187</b>   |                         | 17. INFORMANT<br><b>Niece</b>  |  | ADDRESS<br><b>Eleanor M. Simpson, Same as item 13</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Fracture Rt. Hip</b>   |                         |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR <b>0</b> MIN. <b>17</b> MONTH <b>12</b> DAY <b>17</b> YEAR <b>1979</b>                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fall on Street</b>  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Street</b>   |  | 21f. LOCATION<br>STREET <b>Coleville Rd</b> CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Mont</b> STATE <b>Md</b>  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |                         | TITLE (SPECIFY)<br><b>M.D.</b>   |  | MEDICAL EXAMINER<br><b>John S. Rogers M.D.</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John S. Rogers M.D.</b>  |                         | ADDRESS<br><b>1919 Seminary Rd., Silver Spring, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2/16/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairfax City Cemetery</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>JOSEPH GAWLER'S SONS INC.</b>  |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>   |  |

80840-07

STATION

M.

STATION

100

XX

U.S.A.

100

Owner

Mitchell

H

Place

Harry

London

U

George

77-28-0000

10

1919 January 1st, River Road, N.Y.

John A. Gorman, Jr.

1919 January 1st, River Road, N.Y.

John A. Gorman, Jr.

1919 January 1st, River Road, N.Y.

1919 January 1st, River Road, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 79-04809 |  |
|--|--|---|--|--|--|--|--|--|--|-------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Louis Skinder   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2/18/79  |  | 2b. HOUR<br>3:05 P.M.  |  |                   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3-16-1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7. UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |                   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bel Pre Health Center |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Window Dresser  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Advertising   |  |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Rockville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>14533 Barkwood Drive  |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Brunslav Skinder  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown  |  |  |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>W.W. I  |  | 17. INFORMANT<br>Donald M. Skinder   |  | 18. ADDRESS<br>14533 Barkwood Drive Rockville, Md. 20853   |  |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4/140<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease<br>4 YRS.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |  |   |  |  |  |  |  |  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Pneumonitis  |  |   |  |  |  |  |  |  |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18 9/12 19 79, to 2/18 19 79, that (I) (we) lost the deceased alive on 2/18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |  |  |  |  |  |  |                   |  |
| 22b. SIGNATURE<br>H. T. Bernack MD   |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/18/79  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. T. Bernack MD  |  |   |  | 22e. ADDRESS<br>4115 Colie Dr. Wheaton, Md   |  |  |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/23/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Home Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Forest Park, Illinois   |  |  |  |                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Garrett R. Totum  |  | 24b. ADDRESS<br>3901 N. Fairfax Drive   |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 28 1979   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                   |  |
| Arlington Funeral Home Arl., Va. 22203   |  |   |  |  |  |  |  |  |  |                   |  |

10-01809

NAME: Florence Lillian Smith

DATE OF DEATH: February 2, 1979

PLACE OF DEATH: Montgomery County

SEE: 79- 02181  
January 1979  
Montg. Co.

5040313047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |  |  |   |  | REG. NO.  |
|--|--|--|---|---|---|--|--|---|--|---|
| 1. FOR STATE REGISTRAR   |  |  |   |   |   |  |  |   |  | 79-04810  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert L. Snowden</b>   |  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-1-79</b>  |  | 2b. HOUR<br><b>4:30 PM</b>  |  |   |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12-12-04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>74</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                |  |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Home</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Funeral Director</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |   |  |  |   |  |   |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>Mont.</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>603 Maryland Ave.</b>   |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George R. Snowden</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY CARTER</b>  |   |  |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-34-5206</b>   |   | 17. INFORMANT ADDRESS<br><b>Alma P. Snowden</b>   |   |  |  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Megakaryocytic myelosis</b><br><b>2072</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                 |  |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Lymphoma, tuberculous, terminal bronchopneumonia, GI bleeding</b>  |  |  |   |   |   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |
| 22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb</b> 19 <b>78</b> to <b>1 Feb</b> 19 <b>79</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>30 Jan</b> 19 <b>79</b> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was not</del> ) did not view the body after death. |  |  |   |   |   |  |  |   |  |   |
| 22b. SIGNATURE<br><b>Donald E. Dillon</b>  |  |  |   |   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1 Feb 79</b>   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald E. Dillon, M.D.</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>18111 Pr Philip Dr. Chevy, Md 20832</b>                                   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2-5-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Silver Spring Montg. Md.</b> |   |  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>George R. Snowden</b>  |  |  |   |   |   | 24b. ADDRESS<br><b>246 N. Wash. St. Rockville, Md.</b>                                       |  | 25. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><b>FEB 15 1979</b>   |  |   |



19-04810

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |  |  |   |                  |   |                                     |   |  |   |  | REG. NO. 79-04811  |   |   |   |
|--|---------------------|--|--|---|------------------|---|-------------------------------------|---|--|---|--|--|---|---|---|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><i>Arthur R. Sonntag</i>  |                     |  |  |   |                  |   |                                     |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><i>Feb 3, 1979</i> | 2b. HOUR<br>AM PM<br><i>4:01 AM</i>                             |   |   |
| 3. SEX<br><i>M</i>   | 4. RACE<br><i>W</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Sept. 8 38 40</i>   | 6. AGE IN YEARS<br>(LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><i>40 YRS.</i> | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><i>Feb 3, 1979</i>                  | 2d. HOUR<br>AM PM<br><i>4:02 AM</i> | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, DC</i>                |  |   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery MD.</i> |
| 10. CITY OR TOWN OF DEATH<br><i>Olney</i>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Georgia Ave</i> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Policeman</i> |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Montg. City Police</i>                    |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13b. STREET ADDRESS<br><i>Coat Bridge Place XXXXXXXXXXXXXXX</i> |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Sonntag</i>   |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ruth E. Crooke</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR GATES)<br><i>no none</i> |                  | 16b. SOCIAL SECURITY NO.<br><i>217-36-8797</i>                                    |                                     | 17. INFORMANT ADDRESS<br><i>Betty S. Sonntag-wife-(same as 13e)</i>               |  |   |  |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Multiple Injuries</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Hit by Automobile</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>   |                     |  |  |   |                  |   |                                     |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>None</i>                  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>None</i>   |                     |  |  |   |                  |   |                                     |   |  |   |  |  |   |   |   |
| 19a. DATE OF OPERATION<br><i>None</i>  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                  |   |                                     |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |   |   |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><i>4:05 P.M. 23 19 79</i>  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>Hit by car</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                       |                  |   |                                     |   |  |   |  |  |   |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><i>Street</i>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>Georgia Ave, Olney Mont. Md.</i>                            |                  |   |                                     |   |  |   |  |  |   |   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |  |  |   |                  |   |                                     |   |  |   |  |  |   |   |   |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |                     | TITLE (SPECIFY)<br><i>M.D. Dep.</i>  |  | MEDICAL EXAMINER<br><i>Silver Spring, Maryland</i>  |                  |   |                                     |   |  | DATE SIGNED<br><i>Feb 3 1979</i>  |  |  |   |   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><i>John S. Rogers, DME</i>  |                     | ADDRESS<br><i>Silver Spring, Maryland</i>  |  |   |                  |   |                                     |   |  |   |  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |                     | 23b. DATE<br><i>2-6-1979</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>   |                  |   |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Silver Spring Montgomery Md.</i> |  |   |  |  |   |   |   |
| 24. FUNERAL DIRECTOR'S NAME<br><i>Warner E. Pumphrey, Inc.</i>   |                     | ADDRESS<br><i>8434 Ga. Ave., S.S. Md.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 7 1979</i>  |                  | 25b. REGISTRAR'S SIGNATURE<br><i>John S. Rogers</i>                               |                                     |   |  |   |  |  |   |   |   |

11840-21

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

100% COPY  
EX-111

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04812

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 79-04812                                     |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |
| STELLA   |  | Mae   |  | SPAID   |  |   |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | 7. IF UNDER 1 YR.   |  | 7. IF UNDER 24 HRS.                          |  |
| Female   |  | Cauc.   |  | 9/23/1900   |  | 78  |  | MONTHS  |  | DAYS   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | MD.  |  |
| West Virginia  |  | U.S.A.  |  | WIDOWED   |  | DIVORCED  |  | Montgomery  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |  |  |
| Silver Spring  |  | Holy Cross Hospital   |  | Housewife   |  | Home  |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |  |  |
| West Va.   |  | Hampshire   |  | Highview  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | PO Box 123A   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |   |  |   |  |  |  |
| William  |  | Christina   |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |
| No   |  | 223-44-1582A  |  | E. Olan Spaid   |  | Capon Bridge, W. Va.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction  |  |   |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Infarction   |  |   |  |   |  |   |  |   |  | Yrs.   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |   |  |   |  |  |  |
| None   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  | 20. AUTOPSY?  |  |  |  |
| None   |  |   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR                                    |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
|  |  |   |  | STREET  |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  | M.D.  |  | MEDICAL EXAMINER  |  | DATE SIGNED   |  |  |  |
| John S. Rogers   |  | M.D.  |  | Dep.  |  |   |  | Feb 12 1979   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |  |   |  |   |  |   |  |  |  |
| John S. Rogers   |  | 1919 Seminary Rd., Silver Spring, Md                        |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | CITY OR TOWN  |  | STATE  |  |
| Burial   |  | Feb 15, 1979  |  | Timber Ridge Cemetery   |  | Highview, West Virginia   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |  |  |
| Capitol Funeral Service  |  | FEB 16 1979   |  | Anthony McCreedy  |  |   |  |   |  |  |  |
| NAME   |  | ADDRESS   |  |   |  |   |  |   |  |  |  |
| Fairfax, Va.   |  |   |  |   |  |   |  |   |  |  |  |

19-04815

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 79-04813 |  |
|--|--|---|--|--|--|--|--|--|--|-------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ETHEL Lyddane SPEARE</b>  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>2-22-79</b>  |  | 2b HOUR<br><b>6:15 A M</b>   |  |                   |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 10 1883</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |                   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Rockville Nursing Home</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |  |  |                   |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Montgomery</b>   |  | 13c CITY OR TOWN<br><b>Rockville</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>208 W. Montgomery Ave.</b>  |  |                   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Lyddane</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Fannie Renshaw</b>   |  |  |  |  |  |                   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>579-26-9735A</b>  |  | 17 INFORMANT ADDRESS<br><b>Marian S. Mainhart 212 W. Montg. Ave., Rockville, Md.</b>   |  |  |  |  |  |                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>30 years</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |  |  |                   |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 19 <b>71</b> to <b>2/22</b> , 19 <b>79</b> , that (I) ( <del>was</del> ) lost <del>saw</del> the deceased alive on <b>2/9</b> , 19 <b>79</b> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.       |  |   |  |  |  |  |  |  |  |                   |  |
| 22b. SIGNATURE <b>W. G. Hall</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c. DATE SIGNED<br><b>2/22/79</b>   |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. G. HALL</b>   |  |   |  | 22e. ADDRESS<br><b>615 W. MONTGOMERY AVE., ROCKVILLE, MD.</b>  |  |  |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>2-23-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY ALEXANDRIA, FAIRFAX VA.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |                   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES P/A</b>   |  |   |  | ADDRESS<br><b>ROCKVILLE MD.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |                   |  |

10-04013



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04814

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARION M SPENCER</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 15, 1979</b>                             |  | 2b. HOUR<br><b>2:40 A.M.</b>                 |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 7 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Md</b>   |   |   | 13b. COUNTY<br><b>Mont.</b>  | 13c. CITY OR TOWN<br><b>Brinklow</b>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   | 13e. STREET ADDRESS<br><b>800 Brighton Knolls Dr.</b>                                |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Majewski</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unobtainable</b>                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>116 07 1928</b>  |  | 17. INFORMANT<br><b>Same as above</b><br><b>Ethel M. Hubert (Daughter)</b>     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Basilar Artery Occlusion</b><br><b>4330</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>High Blood Pressure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>79</b> , to <b>2/15</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Brian H. Avin</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/15/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRIAN H. AVIN</b>   |   | 22e. ADDRESS<br><b>6201 Greenbelt Rd. College Pk Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/20/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenfield Cemetery</b>               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Merrick, New York</b>  |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi Funeral Home</b>   |   | ADDRESS<br><b>11800 N.H. Ave Silver Spring, Md.</b>   |  | 25. DATE RECD. BY REGISTRAR<br><b>FEB 22 1979</b>                              |  |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kirby McCready</b>                            |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

92-04814

John Edward Majewski  
116 07 1928 School N. Roberts (Daughter)  
Hastings, N.Y.

Montgomery General Hospital  
Houseside  
800 Brighton Avenue Dr.  
Mont.

Funeral Home Silver Spring, Md.  
11800 N.E. Ave.  
Greenland Cemetery, New York

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |  |   |  |   |  |   |  | REG. NO. 79-04815   |  |
|---|--|---------------|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR<br>NORMAN ALTON STANT<br>Norman A. Stant   |  |               |  |   |  | 2a. DATE KNOWN OF DEATH<br>2-15-1979  |  | 7b. HOUR<br>5 PM  |  |   |  |
| 3. SEX<br>M.  |  | 4. RACE<br>W. |  | 5. DATE OF BIRTH<br>4-12-07   |  | 6. AGE (IN YEARS)<br>71 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, DC   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PEPCO  |  |
| 13a. STATE<br>MD.   |  |               |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>WASHINGTON, D.C.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>6912 GREENVALE STREET, N.W.                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES ERNEST STANT  |  |               |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA MAE VANDERSLICE        |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |               |  | 16b. SOCIAL SECURITY NO.<br>577-05-0845   |  | 17. INFORMANT<br>ELIZABETH K. STANT   |  |   |  | ADDRESS<br>SAME AS 13 WIFE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>4392<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <u>Cardio Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |               |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Diabetes Mellitus</u>   |  |               |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>John B. Ball  |  |               |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |  | DATE SIGNED<br>Feb. 15, 1979  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>JOHN G. BALL  |  |               |  | ADDRESS<br>BETHESDA, MARYLAND   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |               |  | 23b. DATE<br>2/27/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NATIONAL MEMORIAL PARK                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FALLS CHURCH VIRGINIA                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS  |  |               |  | ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 22 1979   |  | 25b. REGISTRAR'S NAME<br>[Signature]  |  |

19-01812

WOMAN ALTON

WASHINGTON, DC U.S.A.

HOSPITAL SUPERVISOR

WASHINGTON, D.C. XX

CHARLES EAST STANT LAURA

77-02-012 ELIZABETH K. STANT

JOHN O. BALL

BRIGAD 2/19/77

FRANCIS J. COLLINS

200 WEST HUNTS... STREET SPRING, MD 20851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                          |  | REG. NO. 79-04816                               |     |           |           |
|---|--|---|--|---|--|---|--|--------------------------|--|---|-----|-----------|-----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH        |  | MONTH   | DAY | YEAR      | 2b. HOUR  |
| Lina  |  | Steiner   |  |   |  |   |  | 2-27-1979                |  |   |     |           | 6:10 A.M. |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR       |  | 8. IF UNDER 24 HRS                              |     |           |           |
| FEMALE  |  | WHITE   |  | SEPT. 10, 1905  |  | 73  |  | MONTHS                   |  | DAYS  |     | HOURS MIN |           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                          |  |   |     |           |           |
| AUSTRIA   |  | U. S. A.  |  |   |  | MONTGOMERY  |  |                          |  |   |     |           |           |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                          |  |   |     |           |           |
| TAKOMA PARK   |  | WASHINGTON ADVENTIST HOSPITAL   |  | MERCHANT  |  | STATIONERY  |  |                          |  |   |     |           |           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS                             |     |           |           |
| MARYLAND  |  | MONTGOMERY  |  | TAKOMA PARK   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  | 7051 CARROLL AVENUE, APT. 401                   |     |           |           |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                          |  |   |     |           |           |
| MORITZ  |  | SCHAFFA   |  | JULIE   |  | GOLDSCHMIDT   |  |                          |  |   |     |           |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                          |  |   |     |           |           |
| NO  |  | 578 46 8384   |  | SEBASTIAN STEINER (SAME AS No. 13)  |  |   |  |                          |  |   |     |           |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY   |  |   |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |     |           |           |
| IMMEDIATE CAUSE (a) <u>Stroke</u>   |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| <u>Perforated Carcinoma of Colon</u>  |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                          |  |   |     |           |           |
| 2/19/79   |  | Carcinoma of Colon  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                          |  |   |     |           |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |                          |  |   |     |           |           |
|   |  | P.M. 19   |  |   |  |   |  |                          |  |   |     |           |           |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY                   |  | STATE   |     |           |           |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/16/79</u> , to <u>2/27/79</u> , that (I) (we) lost saw the deceased alive on <u>2/26/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. |  |   |  |   |  |   |  |                          |  |   |     |           |           |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                          |  |   |     |           |           |
| <u>H. L. Martek</u>   |  | M.D.  |  |   |  |   |  |                          |  |   |     |           |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                          |  |   |     |           |           |
| H. L. MARTEK  |  | 831 University Blvd East  |  |   |  |   |  |                          |  |   |     |           |           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                   |  | STATE   |     |           |           |
| BURIAL  |  | 2/27/1979   |  | MOUNT LEBANON   |  | HYATTSVILLE   |  | P. G.                    |  | MARYLAND  |     |           |           |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24b. DATE REC'D. BY REGISTRAR   |  | 24c. REGISTRAR'S SIGNATURE  |  |   |  |                          |  |   |     |           |           |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  |  | MAR 01 1979   |  | <u>Robert K. B...</u>   |  |   |  |                          |  |   |     |           |           |
| 232 CARROLL STREET, N.W., WASHINGTON, D.C.  |  |   |  |   |  |   |  |                          |  |   |     |           |           |

12-04816

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | REG. NO. 79-04817  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Richard Stojanski</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2. 4. 79</i>                              |  | 2b. HOUR<br><i>7:40</i> AM   |
| 3. SEX<br><i>male</i>  | 4. RACE<br><i>white</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Sep. 7, 1894</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>84</i> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Germany</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>Germany</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>8100 Park Crest Drive</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Engineer</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><i>Maryland</i>  |   | 13b. COUNTY<br><i>Montgomery</i>  | 13c. CITY OR TOWN<br><i>Silver Spring</i>   | 13d. STREET ADDRESS<br><i>8100 Park Crest Drive</i>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Stojanski</i>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Maria Krzeniessa</i>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>577-48-3031A</i>  | 17. INFORMANT<br><i>daughter</i>  |   | ADDRESS<br><i>same as 13</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>venia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>stroke</i> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>1959</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1959</i> 19 <i>2. 4.</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>2. 3. 79</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>H. Paul Arenz</i>   |   | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>2. 4. 79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>H. Paul ARENZ MD</i>   |   | 22e. ADDRESS<br><i>3301 New Mexico Ave N.W D.C.</i>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |   | 23b. DATE<br><i>Feb. 7, 1979</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>                    |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br><i>Sil. Spr. Md.</i>  |   | 23e. COUNTY<br><i>Mont.</i>   |   |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><i>Francis J. Collins</i>   |   | 24a. DATE REC'D. BY REGISTRAR<br><i>FEB 5 1979</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Lifney Kachody</i>                            |  |
| 500 University Blvd., W.   |   | Silver Spring, Md.  |   |  |  |



12-04813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |                       | 79-04818  |  |
|--|--|---|--|---|--|--|--|--|-----------------------|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |                       | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George William Stone  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 21, 1979                             |  |  | 2b. HOUR<br>7:30 P.M. |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 30, 1915  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |                       | 7. UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Not Avail.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |  |                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Clinical Center, NIH |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Not Avail.       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Not Avail.  |                       |   |  |
| 13a. STATE<br>Florida  |  |   |  |   |  | 13b. COUNTY<br>Duval   |  | 13c. CITY OR TOWN<br>Jacksonville  |                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Not Available  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Not Available                       |  |  |                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Not Avail.   |  | 16b. SOCIAL SECURITY NO.<br>--  |  | 17. INFORMANT<br>The Medical Record<br>The Clinical Center, NIH, Bethesda Md  |  |  |  |  |                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 410- Asystole Following CARDIO PULMONARY BYPASS<br>DUE TO, OR AS A CONSEQUENCE OF (b) INTRAOPERATIVE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY VASCULAR DISEASE (OCCLUSIVE)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                             |  |   |  |   |  |  |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs<br>5 hrs                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |                       |   |  |
| 19a. DATE OF OPERATION<br>2/21/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ANGINA PECTORIS   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                       |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                       |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 February 19 79, to 21 February 19 79, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on 21 February 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |                       |   |  |
| 22b. SIGNATURE<br>Richard E. Michalik MD   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  |  |  | 22c. DATE SIGNED<br>2/21/79  |                       |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard E. Michalik MD  |  |   |  | 22e. ADDRESS<br>The Clinical Center, National<br>Institutes of Health, Bethesda, Md   |  |  |  |  |                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/23/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Jacksonville  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Jacksonville Duval Fla.                |  |  |                       |   |  |
| 24. FUNERAL DIRECTOR<br>W.W. Chambers Co. Silver Spring, Md.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                       |   |  |

81840-25

• [civva.com](http://www.civva.com)

Cleared by Dr. John G. Ball 2-3-79

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. <b>79-04819</b>  |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | I. DECEASED NAME<br>(TYPE OR PRINT) <b>Julia M. Strubing</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>3</b> YEAR <b>79</b>  |  | 2b. HOUR<br><b>900</b> A.M.   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>15</b> YEAR <b>1888</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5200 Elsmere Avenue</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5200 Elsmere Avenue</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Wayne</b> LAST <b>Munro</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Georgia</b> MIDDLE <b>Bilbro</b> LAST <b>Bilbro</b>  |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>577 84 1063</b>   |  | 17. INFORMANT ADDRESS<br><b>Julia S. Holtz Same as item 13 a-e</b>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 minutes</b> |  |
| 410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Thrombosis</b>   |  |   |  |   |  |   |  |  |  | <b>30 minutes</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary arterio sclerosis</b>   |  |   |  |   |  |   |  |  |  | <b>years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept-2</b> 19 <b>72</b> , to <b>2-3</b> 19 <b>79</b> , that (we) last saw the deceased alive on <b>Dec 27</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John F. Tauber</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>2-3-79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John F. Tauber</b>  |  | 22e. ADDRESS<br><b>8218 Wisconsin Ave Bethesda MD</b>   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2-4-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Virginia</b>                                   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler Funeral Home, Inc.</b><br>ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John G. Ball</b>   |  |   |  |  |  |   |  |

MEDICAL CERTIFICATION

10-04819

#8 8529 5720719 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04820

REG. NO.

|   |           |                  |   |  |  |   |  |  |
|---|-----------|------------------|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |           |                  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |           |                  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| Margaret L. Sullivan  |           |                  | 2 10 79   |  |  | 10 <sup>00</sup> AM   |  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | IF UNDER 1 YEAR   |  |  |
| Female  | Caucasian | Mar. 20 1924     | 54  |  |  | IF UNDER 24 HRS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |           |                  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| New York  |           |                  | U.S.A.  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |
| Bethesda  |           |                  | 5301 Wakefield Road   |  |  | Montgomery MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   |           |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |
| Bethesda  |           |                  | 5301 Wakefield Road   |  |  | Admin. Asst.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |           |                  | 13b. INSIDE CITY LIMITS?  |  |  | 13c. STREET ADDRESS   |  |  |
| Maryland  |           |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 5301 Wakefield Road   |  |  |
| 14. FATHER'S NAME   |           |                  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |  |
| Albert C. Dale  |           |                  | Anne L. Miller  |  |  | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |
| No  |           |                  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  |
|   |           |                  | 085-12-6541   |  |  | Daughter  |  |  |
|   |           |                  |   |  |  | Mrs. Dale S Parks, 10017 Wedge Way, Gaithers-   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |           |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |   |  |  |
| PART I. DEATH WAS CAUSED BY   |           |                  |   |  |  |   |  |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>  |           |                  | 4 days  |  |  |   |  |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF   |           |                  |   |  |  |   |  |  |
| (b) <u>Coronary thrombosis</u>  |           |                  | 4 days  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |           |                  |   |  |  |   |  |  |
| (c) <u>Atheros</u>  |           |                  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)   |           |                  |   |  |  |   |  |  |
| <u>Atherosclerotic and hypertensive Cardiovascular disease -</u>  |           |                  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |           |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  |
|   |           |                  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |           |                  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |           |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |           |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>77</u> to <u>2-10</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>2-1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |           |                  | 22b. SIGNATURE<br><u>Charles P. Duvall M.D.</u>   |  |  | 22c. DATE SIGNED<br>2/10/1979   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |           |                  | 22e. ADDRESS  |  |  | 22f. DATE REC'D. BY REGISTRAR   |  |  |
| Charles P. Duvall, M.D.   |           |                  | 1145--19th St., N.W. Wash., D.C.  |  |  | FEB 15 1979   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |           |                  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial  |           |                  | 2/13/1979   |  |  | St. Anthony's Catholic Church Cem., Groton New York   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |           |                  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| JOSEPH GAWLER<br>ADDRESS<br>3120 WISC. AVE., N. W. WASH., D. C. 20016   |           |                  | FEB 15 1979   |  |  | Pitney McCready   |  |  |



Handwritten notes and stamps, including "New York" and "Montgomery".

Handwritten notes at the bottom of the page, including "11-1-1941" and "New York".



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |  |  | REG. NO. 79-04821  |  |
|---|--|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Robert Francis Sullivan   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2, 20, 1979  |   |   | 2b. HOUR<br>1:40 P.M.  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MAY 16, 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  |   | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ELECTRONICS PHYSICIST          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>WHEATON  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>4018 ADAMS DRIVE  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>LEO SULLIVAN   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELISE BINGLE   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>WW II 555-22-0417   |  | 17. INFORMANT BROTHER<br>RICHARD SULLIVAN   |  | ADDRESS 435 N.W. TORREYVIEW LANE<br>PORTLAND, OREGON  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Metastatic Squamous Cell Cancer</u><br>(c) <u>Probable Infection</u>                  |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days<br>months |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Probable Infection</u>   |  |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>79</u> , to <u>2/20</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Stephen Newman MD</u>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>2/21/79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEPHEN NEWMAN   |  |   |  |   | 22e. ADDRESS<br>GAITHERSBURG, MARYLAND   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  | 23b. DATE<br>2/22/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>METROPOLITAN CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY<br>ALEXANDRIA VIRGINIA  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS   |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 22 1979   |   | 25b. SIGNATURE<br><u>Francis J. Collins</u> |  |  |  |  |
| 25c. ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |  |   |  |   |   |  |  |  |  |

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TO HOSPITAL: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once returned by the attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once returned by the attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Items 6, 7, 2a g529 3/9/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04822

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|
| 2. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Irene C. Swope</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 14/79</b>                    |   |  | 2b. HOUR<br><b>8:20 PM</b>  |  |  |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 30, 1887</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91-92</b> YRS.                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |   | 13b. COUNTY<br><b>Montgomery</b>   |   |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Schulthies</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Schmidt</b> |   |  | 13e. STREET ADDRESS<br><b>4602 Davidson Drive</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-52-6051</b>                           |   |  | 17. INFORMANT<br><b>son</b><br>ADDRESS<br><b>1107 Bahama Bend<br/>Coconut Creek, Fla.</b> |  |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

|  |  |   |  |
|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Dehydration</b>   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan 3, 19 79</b> , to <b>Feb 5, 19 79</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 5, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>K. S. Kim</b>   |  | 22c. DATE SIGNED<br><b>2/6/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KWANG S. KIM</b>   |  | 22e. ADDRESS<br><b>615 W. Montgomery Ave. Rockville, MD.</b>  |  |

|   |  |                                  |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>Feb. 7, 1979</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D. C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis J. Collins</b>     |  |                                  |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1979</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey A. Brady</b>                  |  |
| 500 University Blvd., W. Silver Spring, Md.                   |  |                                  |  |  |  |  |  |

10-04855